LAY AND PROFESSIONAL CONSTRUCTIONS OF CHILDHOOD ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER): A DISCOURSE ANALYSIS

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Abstract

Childhood ADHD is a contested yet rising public health phenomenon, due to greater use of inclusive American diagnostic classification. In the UK ADHD is considered to be 'incompletely medicalised' with rising incidences predicted. A critical approach was adopted in this thesis, based on a number of social constructionist assumptions in order to examine the emergence and increased use of the construct and to contribute to broader critical debate in the field. Parents and teachers are key adults in childhood ADHD as they may identify and care for diagnosed children yet they have been relatively neglected in the literature. How such adults account for children's difficulties was the focus of an empirical analysis. A 'critical discursive psychology' approach was adopted using Edley's (2001) framework in order to examine culturally available talk by parents and teachers about ADHD, from semi-structured interviews in Scotland. Analysis highlighted how parents deployed contradictory interpretive repertoires in talk using a *Biological repertoire* as a genetic explanation and an *Environmental repertoire* in relation to various parenting issues. Such talk was organised to attend to the ideological dilemma of parental moral adequacy and accountability and which sought to accomplish the '*good parent'*. Further analysis considered how parents accounted for competing versions of the difficulties and their positioning in relation to controversial medication talk. Teacher accounts of children's difficulties deployed an *ADHD repertoire* as a medical condition and a *Not ADHD repertoire* as due to temporal difficulties. Through the '*cases I know*' device, teachers managed their own experiential knowledge and thereby negotiated agency and control for childhood behaviours. Analysis considered accounts of (mis)diagnosis and (mis)treatment as alternative explanations for ADHD. This innovative focus on how health policy for children's difficulties as ADHD were socially produced by lay parent and teachers accounts, highlighted the limitations for agency in ADHD diagnoses and implicated further critical debate about this topic. Parental talk which drew on current biopsychosocial models for ADHD was largely reductionistic and fragmentary. The reliance on discursive efforts about the 'good parent' identity meant that this was a temporal accomplishment in talk rather than achieved by a diagnosis. Analysis of teacher accounts originating from a Scottish context highlighted how they differed from a North American context and provided greater understanding of how teachers succeeded in offering robust alternative explanations to ADHD. The implications for health and education policy of ADHD efforts aimed at the 'education' of teachers may be limited in the face of the teacher talk. Finally, within methodological debate in discourse analysis, this work contributes to further arguments for an eclectic discourse analysis as applied to the field of ADHD.

Keywords: Childhood ADHD; Discourse Analysis; Parent and teacher accounts; Health policy

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Chapter 1: Background to the research

A Contemporary Public Health Area: Child Health and Well-Being

Children's health and well-being is an important area for public health because in developmental terms, it is maintained that healthy children will produce healthy adult members of society. The recent United Nations report (UNICEF, 2007) ranked child well-being amongst rich countries and highlighted that the UK and the USA, despite being two of the wealthiest countries, ranked lowest for child well-being across a range of dimensions. Out of 21 rated countries, for example, the UK ranked particularly low for child material well-being, child educational well-being, family and peer relationships, behaviours and risks as well as child ratings of subjective well-being (UNICEF, 2007:2). These findings suggest that our contemporary practices towards children should be critically examined. How children's health and well-being is defined by adults is important because it has implications for the type of interventions and actions that will be initiated. One area of increasing frequency, following trends in North America, is the increasing diagnosis of children's behavioural difficulties as Attention Deficit Hyperactivity Disorder or ADHD. Here, excessive disruptive behaviour, impulsiveness and inattention are considered to be medically explainable and warranting of medical treatment.

ADHD is a contemporary public health issue which is estimated to affect about 5-10% of all school-children in the UK (NICE, 2000; SIGN, 2001); although not all children are diagnosed. Incidences of ADHD diagnoses are expected to rise in the UK, as well as globally, as a result of inclusive diagnostic criteria adopted. ADHD is one of the most commonly diagnosed conditions of childhood and recent trends have extended ADHD diagnoses to adult populations as well. The research area of ADHD is prolific and controversial with the distinction of being one of the most highly researched areas and yet also one of the most poorly understood. It has generated a furious and emotive coverage in the media and amongst professionals, largely over the contentious origins of the disorder as well as over the use of controversial treatment medications such as Ritalin for school-children. Boys are more likely to receive an ADHD diagnosis than girls. Contemporary writers have also highlighted how boys are, by far, the more likely recipients of other psychiatric diagnoses and conditions such as Autism and Asperger's disorder. Boys are also more likely to underachieve academically and be excluded from school. Boyhood,

therefore, appears as a contemporary ‘problem’. The behavioural characteristics associated with the ADHD phenomenon such as impulsive, spontaneous, inattentive and disruptive behaviour mark it as a particularly challenging one for those living and working with such children, namely parents and teachers.

Parents, Teachers and Childhood ADHD

This work focuses on childhood ADHD because unlike in adult ADHD, children do not refer themselves to specialists or seek medical attention for difficulties with attention and hyperactivity. It is adults who do this, most notably it is parents and teachers who may bring the difficulties to medical attention. Thus, it is parents and teachers who will play a key role in the diagnostic process for ADHD through the identification or defining of the behaviour as problematic. Despite the prolific research in the area of ADHD, such research has tended to be restricted to a scientific paradigm focused on issues of causality and treatments. Little work, for example, has focused on the qualitative experiences of those living with the condition, particularly from a UK context. In addition, while there has been a tradition of critical work in the ADHD field, there has been little work which has combined a critical approach with empirical work.

The research area of ADHD provides a unique and fertile arena in which to explore the increasing medicalisation of children’s behaviour in the UK context. This work is concerned with the way in which children’s difficulties or differences with attention and activity have come to be increasingly called ADHD in a UK context. The thesis is not concerned with generating further knowledge about ADHD in an effort to provide ‘answers’. Instead, this is a critical work in the sense that it aims to problematise current conceptions as ADHD and this is a theme which will be consistently explored across professional constructions of ADHD, as well as lay constructions. A critical approach to ADHD is not new in a highly contested area, but the central tenet of this work is that a critical approach offers a useful framework in which to reconsider this area. It allows debate and transparency over practices in order to make them accountable. In taking a critical approach however, it is not the case that people’s suffering or distress is regarded as merely socially constructed. Rather, this work maintains that it is necessary to challenge and critically consider whether our present ways of describing this behaviour, as an underlying condition called ADHD, are appropriate and beneficial. The tenet of this work therefore shifts the focus away from ADHD as an example of underlying child pathology towards an

analysis of the function and the limits which such a diagnosis affords those adults that seek to define it in those terms, such as the medical profession, parents and educators.

In taking an essentially critical perspective this work focuses on the social processes involved in defining children's difficulties as ADHD. By considering approaches which emphasise the wider medical, social and cultural practices which constitute children's difficulties as ADHD, this work also offers an empirical study of lay talk by parents and teachers about children's difficulties as ADHD. The focus on parents' and teachers' everyday discursive practices about ADHD is a novel approach in ADHD research. In this way, the research provides greater understandings about the limits and the possibilities which an ADHD diagnosis affords parents and teachers from an area in Scotland. This work takes a 'critical discursive psychological' approach in order to provide a critical stance to language use about ADHD as both a cultural artefact and a tool for individual users to draw from in order to constitute experience. Such language use by parents and teachers is therefore significant to investigate because it is held that how we define and talk about a topic, will have material and practical implications for how we can act about this topic.

In essence, this critical and empirical work offers an innovative exploration of how such adults with day-to-day contact with children labelled as ADHD, socially produce children's difficulties and so provides opportunities for considering how current health policy of ADHD is taken up in everyday talk about this topic. Tied to a consideration of the broader historical and socio-cultural context of the area, this work makes a unique contribution to the field of critical ADHD.

A Research Interest

This work on critical approaches to childhood ADHD stems from a range of personal influences including: working with children in diverse settings such as a primary school in South Africa, international summer camps in the USA, Holland and Switzerland, and childcare in the UK; influences from my masters degree in health psychology from social constructionist ideas, discourse analysis and critical health psychology; work experience as a research assistant in the National Health Service (NHS) in Scotland in the ADHD field. It represents an underlying interest in the area of child health and well-being and a conviction that it is an area that deserves critical attention and debate. In such wealthy countries as the UK and the USA, where poor

outcomes were indicated for child well-being, it is argued that critical debate is warranted rather than complacency about current practices. It is maintained that difficult questions need to be asked in relation to underlying cultural assumptions and in relation to adult practices with regards to the constitution, identification and reification of children's difficulties as ADHD.

Chapter Outline

The thesis is concerned with constructions of ADHD and attempts to critically consider the implications of these constructions. Broadly, it looks at how medical professionals have come to label such difficulties in the way that they do and what this entails for those that live with such definitions.

Chapter 2 takes this scientific starting point and outlines the contributions and limits for three main approaches to ADHD. First, the dominant biomedical approach to ADHD is considered; secondly, the growing popularity of the biopsychosocial approach is outlined. Finally, approaches broadly conceptualised as alternative and complementary approaches to ADHD are delineated. Epistemological and methodological discussion of these approaches highlights the underlying biological reductionism in these approaches. This relates to: limits to challenging the biomedical construct of 'ADHD', the emphasis on medication treatment or alternative treatment, quantitative and clinical trails in the research and a failure to consider subjective experiences and socio-cultural aspects of diagnosis.

Chapter 3 turns the focus to a review of the contribution of qualitative research in the area of parental experiences with having a child diagnosed with ADHD. There is limited research in this area and common themes from the review are discussed in relation to parental experiences and ADHD from studies reporting a range of cultural contexts and employing different methodologies to understand this area. The main themes from the review share similarities with the broader field of parenting a child with disabilities, as well as differences. Epistemological and methodological limitations with the research are also considered. Broadly the critique rests on the humanist epistemology which underpins much of this work. It is argued that, while a valuable redress in the research, such approaches are ultimately limited in the critique that they offer to ADHD. Tied to this is the largely 'realist' perspective taken towards language use and a neglect of how social processes are bound with and constitute subjective experience. This entails a

radical shift in epistemology towards the influence of language which is taken up in the next chapter.

Chapter 4 outlines the value and contribution of critical approaches to ADHD. The focus in critical approaches has been to challenge ADHD from various assumptions underpinning social constructionist ideas. Thus, attention has been drawn to the limits of individual child pathology models in psychiatry and developmental psychology, in favour of a wider consideration of contextual aspects in ADHD. Critical approaches stemming from North America have also influenced critique in other contexts such as the UK and this remains a contemporary focus as seen in recent influential publications. Attention to the historical and cultural emergence of ADHD and current medical and clinical practices of ADHD, from a sociological perspective, serves to offer a challenge to ADHD. Methodologically, studies focusing on social processes as in discourse analysis have added valuable understandings from this perspective. Limitations with work in this area have been over limited empirical studies and a tendency to privilege broad theoretical and social aspects in such analyses at the expense of a closer examination of everyday practices in ADHD.

In Chapter 5 the present empirical study is outlined from semi-structured interviews held with parents and teachers in a local health area in Scotland. From the broad field of discourse analysis, a 'critical discursive psychological' approach was adopted, following Edley's (2001) analytic framework of the interpretive repertoire, subject positions and ideological dilemmas. This framework essentially enabled focus on culturally available patterns of language use about ADHD and the implications of their use for the parent and teacher participants. This framework draws on discursive psychology and the conversation analytic insight of grounding analytic claims in participants' orientations and use of language. It also makes use of the broader and wider context in which such talk occurs. This approach is an innovative application of the eclectic use of discourse analysis in the field of ADHD and in response to limits with polarities in the field of discourse analysis.

Chapters 6 and 7 represent the empirical analysis of the study in which parents' and teachers' accounts of children's difficulties and ADHD are presented. Chapter 6 highlights the competing interpretive repertoires and contradictory subject positions available for parents in talk about the origins of the child's difficulties. The analysis shows how parental accounts were organised around the ideological dilemma of parental accountability for the difficulties. The chapter is concerned with

an exploration of how the ideological dilemma is resolved in parental talk. Further analysis demonstrated how parental talk is able to attend to the availability of competing views by others' and yet offer robust explanations for the child's difficulties. A parallel was drawn from classic work in discourse analysis. Finally, the analysis examined parental talk about controversial medications like Ritalin in order to consider parental subject positioning in relation to this major treatment for ADHD.

Chapter 7 outlines contradictory interpretive repertoires deployed by teacher talk in relation to children's difficulties. Such talk was, perhaps unsurprisingly, different to parental talk and designed to attend to an ideological dilemma relating to teacher empowerment and management. The analysis was concerned with exploring how teacher talk attended to resolving such a dilemma and highlights a common metaphor and idiom deployed in accounts. Further analysis of teacher accounts highlighted how teachers were able to present alternative explanations for the child's difficulties in the face of increasing ADHD diagnoses. The implications of these alternative accounts were considered for teacher subject positions in ADHD.

Chapter 8 considers the discursive positioning of parents and teachers in talk about ADHD and draws from the analysis gleaned from chapters 6 and 7 in order to extend these insights. The chapter discusses the main findings in relation to the broader literature on ADHD as well as existing health and education policy. The discussion highlights what an individualised view of childhood difficulties as ADHD, as tied to contemporary individualistic notions of health and illness and child development, entails for positioning by parents and teachers.

Chapter 9 consists of a summary and discussion of the main contributions of the present thesis. It also consists of a reflective account of the methodology used in the study in order to reflect on wider methodological debates in discourse analysis. Areas for future study in ADHD are also considered here.

Chapter 10 offers the main conclusions and recommendations of the thesis as well as the implications of the findings for practice and health policy regarding ADHD. It offers recommendations for such policy based on this work.

Chapter 2: Introducing the ADHD Construct

Introduction

ADHD originates from a biomedical approach to children's problem behaviour and is defined as such from the latest version of the American Psychiatric Diagnostic and Statistical manual (DSM-IV, 1994). There is a vast literature in the ADHD field. Currently there are various approaches towards the construct of ADHD and this chapter is concerned with outlining these approaches as: a biomedical approach, a biopsychosocial approach as well as alternative and complementary approaches. The starting point, however, is the influential biomedical approach with its focus on classification and diagnosis, prevalence, prognosis, aetiological aspects and treatment approaches. Underlying the biomedical construction of ADHD is a positivist epistemology which has been concerned with elucidating advances in scientific understandings about this controversial condition. A biopsychosocial approach, by contrast, is currently favoured in UK contexts where there is recognition of the multiplicity of contributing factors involving biology, psychology and social factors. Post-positivist notions underlying this approach encourage further scientific study in order that potential 'risk' and 'protective' factors be elucidated. From a biopsychosocial approach, however, the construction of an essential biological condition of ADHD remains largely unchallenged and this exists as a form of biological reductionism. Alternative and complementary approaches to ADHD are diverse. Generally these approaches to ADHD struggle in the face of the evidence-based approaches characterising the biomedical and biopsychosocial approaches. A recent flurry of interest in this domain – particularly in the area of diet – has resulted in greater research attention in this area in order to compete with the dominant approaches. Such alternative and complementary approaches, while they may offer the potential for alternative conceptions, tend to be limited however and do little to challenge current conceptualisations of ADHD as a biomedical construct. Finally, while the dominant approaches to ADHD are reflected in current health policy guidelines for ADHD, there are a number of epistemological and methodological limitations associated with these approaches which are highlighted in this chapter.

The Biomedical Construction of ADHD

The biomedical construction of ADHD can be defined as an approach which is rooted in biomedicine. Through this conceptual framework, it is possible to conceive of children's behavioural difficulties as a biomedical condition – as ADHD. This approach is tied to a positivist epistemology which maintains that greater scientific study and empirical investigations will yield further advances in understandings and knowledge about ADHD. (This thesis adopts an alternative epistemology which is elucidated further in chapter 5). The empirical tradition of experimentation and scientific investigation is used to confirm the biological basis of ADHD. This is recognisable as the dominant approach in contemporary Western conceptions of medicine and is characterised by diagnosis, disease and drugs (e.g. Marks, Murray, Evans and Willig, 2000). Within this conception, it is possible to frame ADHD as a discrete condition and outline its classification, prevalence, aetiology, prognosis and treatment. Thus it is through this approach that it is possible to talk about 'ADHD' at all and attempts at classification and identification as well as treatments are made possible. Conrad and Schneider (1992) refer to changing conceptions of children's deviant behaviour from being seen as 'badness' to 'sickness' and as rooted in Western, industrial societies which have a scientific worldview rather than a moral or religious one. The biomedical construction of ADHD is an extensive research area which will be outlined below in order to consider the field.

The Classification of ADHD

Within the biomedical framework, ADHD is considered to be a neurodevelopmental condition. Here, ADHD is seen to be characterised by difficulties with attention, impulsivity and/or hyperactivity. According to the latest version of the Diagnostic and Statistical Manual (DSM-IV, 1994) the following is specified: at least six symptoms of inattention or hyperactivity-impulsivity must be present for a minimum of six months and must cause significant interference with developmental functioning. In addition these symptoms must have been present before age seven, there must be evidence of impairment in two or more settings (i.e. at home and at school), symptoms should be pervasive and not be able to be explained by the presence of another mental disorder. Three subtypes of ADHD are currently specified: an inattentive subtype, a hyperactive-impulsive subtype and a combined subtype. In the inattentive subtype, symptoms include inattentiveness and distractibility. The hyperactive-impulsive

subtype includes symptoms of hyperactivity, impulsivity, and disruptive behaviour. The combined subtype includes symptoms of both inattentiveness and hyperactivity. It is important to note that the term 'ADHD' (or attention deficit hyperactivity disorder) arose out of this DSM-IV classification and most research is conducted on children with this diagnosis. Earlier DSM-III classification specified the term 'ADD' (or attention deficit disorder) which could occur with or without hyperactivity while later DSM-III-R classification indicated a single disorder which included symptoms of inattention and hyperactivity/impulsivity (Conners, 2000). Current DSM-IV is seen as a return to the earlier DSM-III which indicated different subtypes, with an additional subtype specified. The changes of definition are seen to reflect a debate over the significance of hyperactivity symptoms and inattention (Conners, 2000). The validity of the subtypes of ADHD as separate and distinct disorders in their own right, have also been questioned (e.g. Milich, Balentine and Lynam, 2001; Lahey, 2001). There has also been recent questioning of the 'attention deficit' label by leading proponents, in favour of deficits of working memory or executive functioning (Barkley, 2006a). (Chapter 4 considers the historical emergence of ADHD in more detail).

The European World Health Organisations' International Classification of Diseases tenth version (ICD-10, 1993) exists as alternative classification system in European contexts and which has been traditionally adopted in the UK. This classification system currently specifies 'hyperkinetic disorder' as severe and enduring, persistent hyperactivity. With recent ICD-10 criteria, however, there is a growing similarity with DSM-IV for ADHD symptoms. The main difference is that ICD-10 remains typically narrower for ADHD symptoms than DSM-IV. This is because ICD-10 requires symptoms of each of inattention, over-activity and impulsivity for a diagnosis whereas DSM-IV allows division into subtypes and thus does not specify an overlap of symptoms. Thus while hyperactivity remains as a defining feature for ICD-10, it is only one subtype in DSM-IV (i.e. it is possible through DSM-IV to receive a diagnosis of ADHD-inattentive subtype while this is not possible for ICD-10). ICD-10, in addition, while narrower than DSM-IV, has become much broader than previous classifications (i.e. ICD-9 for example). While DSM classifications reflect American Psychiatric Association definitions of the disorder, the growing popularity of the term and classification is influential in the UK. For example Geoffrey Kewley (1998), a paediatrician and leading proponent of ADHD in the UK, argued that ADHD is under-diagnosed and under-treated in the UK – unlike

the USA for example where concerns of over-diagnosis exist (e.g. DeGrandpre, 2000). Kewley argued that more professionals should use DSM-IV criteria in defining ADHD as they are more inclusive and allow for a broader consideration of difficulties than ICD (Kewley, 1998). Recent research in support of this has highlighted the predictive validity over both classification systems but which maintained that the ICD-10 criteria for hyperkinetic disorder tended to under-identify symptoms of ADHD (Lahey et al, 2006). Thus, the very term 'ADHD' as noted above, reflects DSM-IV nomenclature. Critics in the UK have argued, in response, that children at the severe end of the spectrum may become trivialised by current DSM-IV classification and the British Psychological Society's working party in 1996 advocated that stringent criteria based on 'hyperkinetic disorder' be used when making a diagnosis (e.g. Reason, 1999).

The difficulties and complexities with competing classification systems for ADHD in the UK are best illustrated by a recent survey amongst child psychiatrists and paediatricians. McKenzie and Wurr (2004) surveyed paediatricians (465) and child psychiatrists (444) regarding their practice and approach to attentional problems. The authors found that a variety of approaches were used: half of the child psychiatrists used the ICD-10 criteria to make a diagnosis of ADHD in comparison to less than a quarter of the paediatricians. About one third of both groups used DSM-IV criteria to make a diagnosis. Over a quarter of the paediatricians and 4% of the child psychiatrists did not use one particular formal classification system. This variability found amongst specialists was noted and, according to the authors, use of both the DSM and the ICD criteria together did not complement each other. They noted that while ICD criteria were still the most widely used in the UK, DSM criteria were most commonly known in the media and amongst the public (McKenzie and Wurr, 2004). It is clear that there has been a relative import of DSM terminology into a UK context through the use of greater information technology which accounts for its popularity in the media and public opinion but also amongst professionals.

The Prevalence of ADHD

In the first upgrade of the European Clinical Guidelines for Hyperkinetic disorder, the authors recognised methodological differences between countries and socio-cultural factors as significant for accounting for differences in prevalence estimates (Taylor

et al, 2004). A number of researchers have posited caution in interpreting prevalence estimates for ADHD in view of the differing definitions of the disorder according to differing classification systems, as highlighted above (i.e. Taylor et al, 2004). Initially, ADHD appeared to be a problem plagued by Western, industrialised, English-speaking countries and was particularly considered to be an American phenomenon. The highest prevalence estimates were found in North America, with prevalence estimates for Europe increasing. Cross-cultural studies have also claimed that ADHD is on the increase in developing countries (e.g. ADHD was estimated between 6-10 % in Africa; Kashala, Tylleskar, Elgen, Kayembe and Sommerfelt, 2005; Ofovwe, Ofovwe and Meyer, 2006; Hyperactivity Association of South Africa). Prevalence estimates have traditionally ranged between 1.7 – 17.8% of the population of schoolchildren in the literature, with American populations typically reporting higher rates for ADHD. In the USA estimates have ranged from 5-7% of schoolchildren in Guevara (2001), 7-8% by Barkley (2006), while Breggin (1999) cited estimates of 10-12% from the International Narcotics Control Board (1998). According to DSM-IV, prevalence estimates are more conservative at 3-5%. Prevalence estimates for the UK have traditionally been much lower with 1-2% of schoolchildren considered to have the more severe hyperkinesis (Lord and Paisley, 2000; in Parr, Ward and Inman, 2003). Currently the National Institute for Clinical Excellence (NICE, 2000) estimated 5% of children in England and Wales and similarly the Scottish Intercollegiate Guidelines Network (SIGN, 2001) estimated 5-10% of schoolchildren in Scotland as prevalence estimates for ADHD. There is general recognition in the UK that American estimates remain higher because of traditionally inclusive classification and also that as UK specialists make increasing use of the DSM-IV, and with greater awareness of the disorder in the UK, the prevalence estimates will be affected. Hence there have been predictions that there will be rising incidences of ADHD in the UK as more children will continue to meet the broader diagnostic criteria found in DSM-IV (e.g. Hill and Taylor, 2001; Olfson, Gameroff, Marcus and Jensen, 2003).

Worldwide prevalence estimates for ADHD were recently attempted based on a literature search and found to be 5.29% (Polanczyk and Rohde, 2007). The authors noted that methodological differences between countries were likely to account for differences in reported prevalence. Similarly Skounti, Philalithis and Galanakis (2007) concluded in their consideration of the prevalence estimates that

population characteristics, methodological factors, as well as ethnic and cultural differences and the diagnostic criteria used, would affect the prevalence of ADHD.

One way of examining the differences in ADHD diagnoses between countries has been to examine patterns of psychostimulant medication use between countries (as the primary treatment for ADHD and hence as an indication of children seen to be classified as ADHD). Berbatis, Sunderland and Bulsara's (2002) comparative study is illuminating where the authors compared Australia with nine other developed countries during the period 1984-2000 using standardised measures. Perhaps unsurprisingly the USA, followed by Canada, were the highest users of psychostimulants for ADHD. Australia and New Zealand ranked third and fourth, with the UK appearing fifth. France, Denmark and Sweden had very low rates of psychostimulant use in comparison. The work of Berbatis et al (2002), as well as highlighting international differences, also highlighted national differences within Australia. Western Australia had particularly higher rates for psychostimulant medication which raised concern. In a similar vein, Quality Improvement Scotland's publication of the Health Indicators Report (2004) – 'A Focus on Children' sparked controversy when it found that Fife had significantly higher rates of psychostimulant use for ADHD for children aged 6-14, in comparison to the national average for Scotland or England. This prompted an investigation by Quality Improvement Scotland which funded an audit to investigate regional differences for ADHD practice across Scotland.[*]

Finally, boys have typically outnumbered girls for ADHD diagnoses by four times (e.g. SIGN, 2001). There was uncertainty in the biomedical literature as to whether this reflected a genuine gender basis for ADHD predisposition or whether boys were simply more likely to be identified displaying difficulties. The latter explanation has generally been held to account for the differences. Girls, in comparison, have been seen as remaining largely undetected, particularly for the inattentive subtype which is less disruptive and so less noticeable.

[*] The first stage of the audit was published in 2007 as: 'ADHD –Services over Scotland'. The report was a profiling exercise for the different local health areas and indicated that prescribing rates had not significantly changed since the 2004 publication. There were also difficulties in estimating prevalence rates due to a lack of overarching data systems. The second stage of the audit is due for publication in 2008.

Aetiological factors involved in ADHD

Addressing the causal factors involved in ADHD, Shelton (2003), for example, noted that these ultimately implicated biological factors as significant although other aspects may contribute. The area of aetiology in ADHD is a complex area with various avenues explored and extensive research in the area devoted to such investigations. A predominant causal explanation has implicated brain abnormality in the prefrontal cortex area (e.g. Tannock, 1998; Thapar and Thapar, 2003). In this explanation, a lack of circulation in the brain of the neurotransmitter dopamine is held to be intrinsic in the condition. Dopamine is essentially responsible for behavioural inhibition and hence the behavioural characteristics associated with ADHD as impulsiveness, distractibility and inattention, are regarded as underlying such dopamine deficiencies. In terms of brain abnormalities, further neuropsychological cognitive response inhibition has been implicated in affecting the executive functions related to behaviour (Barkley, 1998, 2006a). ADHD is thus considered to be a neurodevelopmental disorder in the biomedical literature. Related to this, a genetic predisposition to ADHD has been strongly supported in the literature (e.g. Tannock, 1998). Candidate genes have also been isolated in relation to these dopamine theories (e.g. Elia, Ambrosini and Rapoport, 1999; Swanson, Posner, Fusella, Wasdell, Sommer and Fan, 2001; Levy and Hay, 2001). Brain structures have also been investigated using magnetic resonance imaging (MRI scans). As noted by Shelton (2003) however, the evidence has been inconclusive in this area along with other biological explanations that have identified a small number of brain injuries or toxins such as lead for ADHD causality.[†] Finally, the prominence of genetic research in ADHD may be epitomised by the comment on the publication of *Attention, Genes and ADHD* (Levy and Hay, 2001) by leading ADHD proponent Professor Russell Barkley as:

> Behavioural and molecular genetics is the cutting, nay the bleeding, edge of scientific research into ADHD at the moment. Numerous teams worldwide are racing each other to attempt to isolate the multiple genes contributing to the prevalent disorder of children and adults… (Barkley, 2001, back cover).

[†] Critics such as Peter Breggin have argued that such studies are flawed because of the tendency to study the brains of children that have been taking psychostimulant medications and so may have been structurally affected by the medications themselves.

Despite the extensive research into the field of aetiology for ADHD, however, the controversy surrounding ADHD exists because despite a wealth of research into the various aetiological pathways, there are still no clear biological markers or models which exist to account for the condition. This has meant that various bodies have questioned the validity of the ADHD construct. For example, the National Institute of Health concluded in 1998 that there was a lack of evidence to support ADHD as a disease entity without a single biological basis to it.

Prognosis of ADHD

A diagnosis of childhood ADHD has generally been associated in the literature with a range of negative outcomes. The poorest outcomes for ADHD have generally been associated when ADHD occurs with conduct disorder. The following are examples of patterns reported in the literature: a diagnosis of ADHD has been associated with a poor prognosis for academic achievement (e.g. Fergusson, Lynskey and Horwood, 1997) and low self-esteem (e.g. Kelly, 1989; Bussing, 2000). In addition, negative peer interactions have been reported, and for children with higher IQ's, high levels of academic achievement and conduct disorders, with later substance abuse (e.g. Molina and Pelham, 2001; Flory and Lynham, 2003). A diagnosis of ADHD on its own and treatment with psychostimulant medication, however, has not been linked with later substance abuse (e.g. Barkley, 2003; Wilens et al, 2003). Adult psychiatric disorders have also been associated with a diagnosis of childhood ADHD, particularly amongst girls (e.g. Dalsgaard, Mortensen, Frydenberg and Thomsen, 2002). Poorer outcomes for ADHD amongst adolescent boys have been associated with co-morbid conduct problems, low parental socio-economic status and lower IQ (Willoughby, 2003). In addition further associations have been reported with a childhood diagnosis of ADHD and with later employment difficulties, greater risk of car accidents, greater sexual health risks and antisocial activities in adulthood (Barkley, 2006b).

The presence of an additional psychiatric condition or co-morbidity has been consistently reported in the literature for ADHD. For example, the presence of an additional psychiatric disorder was rated between 18-35% (Guevara, 2001) to 50-75% (Pelham, Wheeler and Chronis, 1998; Tannock, 1998). Oppositional Defiant Disorder and Conduct Disorder, which relate to disorders characterised by behavioural defiance and aggression, were the most consistently reported in the

literature between 40-90%; followed by mood disorders (between 15-20%), anxiety disorders (at 25%) and specific learning difficulties (at 20%) (Tannock, 1998). Additional difficulties have included developmental coordination difficulties (up to 40%); speech and language difficulties (30%) and diagnoses of Asperger's Syndrome or autism (Kewley, 2006). Multiple co-morbidities or the presence of more than one additional psychiatric disorder, have also been frequently reported (estimated at 28% in some samples). It is noteworthy that many studies do not report the presence of multiple co-morbidities at all. The high levels of co-morbidity and multiple co-morbidity associated with ADHD as well as the heterogeneity of the different subtypes, have meant critics have questioned the validity of the construct, with 'pure' cases of ADHD appearing as the exception rather than the norm. Adult diagnoses of ADHD are a recent phenomenon, along with the view that ADHD occurs across the lifespan and not solely in childhood or adolescence. Symptoms associated with childhood ADHD, however, have also been regarded as declining with adulthood (Shelton, 2003). Finally, untreated ADHD has also been associated in the literature with poorer outcomes such as injuries in childhood (Barkley, 2006b) or later criminal behaviour, school exclusion, substance abuse, conduct disorder, teenage pregnancy, lack of motivation and complex learning difficulties (Kewley, 2006).

Treatment of ADHD

The main treatment for ADHD according to SIGN (2001) comprises psychostimulant medications: 'as the first line of drug treatment for the core symptoms' (2001:12). Psychostimulant medication includes methylphenidate and dexamphetamines. Methylphenidate is the most commonly used, such as Ritalin or Equasym. A long-acting methylphenidate, called Concerta works as a slow release version throughout the day. The way in which the medication works is as a central nervous system stimulant (Nice, 2000). Consistent with the dopamine theories, the medication stimulates increased levels of extracellular dopamine so that behavioural inhibition can occur and impulsivity controlled (Thapar and Thapar, 2003). The psychostimulants used are controversial as a Schedule 2 controlled drug (i.e. with addictive properties similar to cocaine or morphine). Straterra is a non-psychostimulant medication which was recently introduced for use with some children. The side-effects of the psychostimulants may include weight loss due to a

lack of appetite, sleep difficulties and nervousness (Nice, 2000). While medication has remained the primary treatment in ADHD, non-pharmacological treatments are also sometimes used and include psychosocial interventions with the family and psychoeducational interventions at school (SIGN, 2001).

Although there are a considerable number of treatments available for ADHD there are three types of treatment that have been investigated according to controlled clinical trials and found to be effective. These three will be outlined here as they feature in the biomedical literature: medication treatments, behavioural management treatments and combined or multi-modal treatments (i.e. which use both medication and behavioural management techniques) (Goldman, Genel, Bezman and Slanetz, 1998; Elia et al, 1999; Gillberg et al, 1997; Multimodal Co-operative Treatment study, 1999; Pelham et al, 1998). Treatment in the area of ADHD is an extensively researched area with most research originating from a North American context and focused on the effectiveness of psychostimulant medication; in contrast to those of behavioural treatments. Until relatively recently, such research has consistently demonstrated the effectiveness of medications as superior (e.g. the review by Schachter, King, Langford and Moher, 2001). Despite this there were distinct limitations with the research in this area. Most notably involving a lack of long-term studies (i.e. studies were seldom beyond 14 months); the failure to demonstrate the benefit of medication in areas such as academic achievement and socially with peer interactions; individual differences to the medication such as non-response (estimated at 30%) and side-effects (as mentioned above) (e.g. Pelham et al, 1998). Political critique has also pointed to the tendency for the treatment trials to be sponsored by drug companies which profit from the market created by rising ADHD diagnoses and requirements for treatment (e.g. Breggin, 1999). Finally, medication approaches have also been accused of failing to consider the broader aspects that may be involved in such behaviour such as the role of the family and school environment (Diller, 1998). By stark contrast, behavioural treatments and combined treatments have only recently been investigated according to controlled clinical trials. Behavioural modification or contingency management was consistently found to be effective for ADHD according to the review by Pelham et al (1998) while individualised cognitive behavioural therapy was not. The SIGN guidelines (2001) maintained that: ‘While the core symptoms of ADHD/HK can be managed effectively with drugs, there is less evidence that psychosocial interventions have a significant effect on these

symptoms' (2001:9). The conclusion was that these interventions may be useful for managing co-morbid conditions and that more research was needed to evaluate effectiveness. Two areas that were regarded as useful included: family psychosocial interventions and school based interventions. This involved: parent behaviour management training and school interventions such as directed instruction, small class size and interactive learning. Combined treatments were also found to be effective (e.g. Multimodal Co-operative Treatment study, 1999), although initially the benefits of this treatment over medication-only approaches were not demonstrated (e.g. Klassen, Miller, Raina, Shoo and Olsen, 1999).

In relation to the above, the most comprehensive and influential study in the ADHD treatment literature was the National Institute for Mental Health's Multimodal Co-operative Treatment Study in the USA (MTA, 1999) which will be reviewed here. The study investigated the long term effects of combined treatments with other forms of treatments using a randomised controlled trial and a large sample (579 children). There were four treatment groups: a combined treatment group (consisting of medication and behavioural interventions), compared with a behavioural-only treatment group, a routine community care group (which consisted of medication only) and a carefully monitored medication group (which titrated medication for each individual). The study used multiple outcome measures in order to evaluate the treatments across: ADHD symptoms, aggression/opposition, internalising symptoms, social skills, parent-child relations and academic achievement. The results of the study indicated that all four treatment groups had in fact shown improvements at 14 months (the cut-off point). The greatest improvements had, however, been observed with the combined treatment group and the carefully managed medication group. These two groups were indistinguishable from one another in terms of statistical differences. A further significant finding was that the levels of medication in the combined treatment group were lowered over the course of the study indicating that less medication was needed when combined with behavioural treatments.

There was considerable controversy over the interpretation of the MTA results, especially over the lack of significant differences found between the combined and carefully managed medication groups which meant that critics could question whether the expense and utility of the behavioural treatments was justified as medication is considerably more cost-effective and less time-consuming than behavioural treatments (e.g. Pelham, 1999; Carey, 1999; Steer, 2005). The authors

of the MTA, however, drew attention to the superiority of the combined treatments over the medication managed treatments according to mean differences across most of the comparison outcomes. They also highlighted that the combined treatments were superior to the other treatments for non-ADHD symptoms such as aggression/opposition symptoms, internalising symptoms, teacher-related social skills, parent-child relations and reading achievement. In addition, according to parent satisfaction ratings, the combined treatments and the behavioural treatments were preferred over the purely medication approaches. Later the authors revisited this issue and performed a series of statistical post hoc analyses, using a single primary outcome measure, to show that the combined treatments were significantly superior to the medication managed treatment group (Conners et al, 2001).[‡]

Since the publication of this study, treatment guidelines for ADHD have favoured multimodal treatments as the current 'gold standard' of treatment (e.g. SIGN, 2001; NICE, 2000; the British Psychological Society's (BPS) Guidelines for ADHD, 2000). Current widespread acceptance of multimodal treatments within health policy has tended to obscure the controversy over the MTA findings and over its methodological weaknesses, however. The weaknesses of the study have been highlighted by others and includes: the lack of placebo or control group, the absence of double-blind conditions, the lack of long term treatment (i.e. 14 months only), the lack of a representative sample (i.e. using boys aged 7-9.9 years old) (Carey, 1999; Breggin, 2001; Klein, 2001). More severe criticism levelled at the study comes from the psychiatrist Peter Breggin (2000; 2001), an outspoken anti-medication advocate and includes: the failure of the MTA to consider or acknowledge the contentious nature of ADHD and the fact that the MTA trial was conducted by pro-medication researchers and co-sponsored by drug companies which indicated a clear vested interest. In addition, he argued that there was a bias against the behavioural treatments because they were withdrawn before the end of the 14 months and assessed at a different time to the medication treatments. Other bias included not reporting the side-effects of the medication and of priming parents and teachers to 'pro-drug propoganda' (i.e. in relation to the safety of the medication for children and over the presumed aetiology for ADHD). Breggin (2000; 2001) also argued that the results may have been confounded because those children in the medication groups had tended to be on medication before the study commenced (i.e. ceiling effects).

[‡] In statistical terms, the authors had been concerned that Bonferroni corrections across the multiple domains had meant that the significance between the groups had been reduced in the original analysis.

He highlighted further that the only blind conditions involved classroom-raters, who found no differences amongst any of the treatment groups. Further, that the children themselves did not rate themselves as improved in any of the treatment groups.

It is clear, from the above, that although the MTA was considered to be a landmark study in ADHD treatment, the results were not without serious methodological weaknesses which should be considered. Despite a lack of 'evidence-base' for multimodal treatments as indicated above, they remain as the current 'gold standard' of treatment, including in a UK context. While the UK recognises the limitations of research conducted in an American context for applicability to a UK context (i.e. SIGN, 2001), it is clear that the MTA results have had a considerable effect on health policy. This bears some consideration. It was clear from the MTA study that parents were not satisfied with medication-only approaches for ADHD, this has also been reported elsewhere (e.g. Bussing and Gary, 2001; Bussing, Zima, Gary and Garvan, 2002). The unpopularity of medication-only approaches therefore, both by parents and arguably exacerbated in the media for example, means that multimodal treatments may remain as a more palatable treatment for ADHD than their medication-only counterparts and explains their widespread acceptance. It is clear also that the emphasis towards multimodal treatments as opposed to medication-only treatments has signalled a change in the construction of ADHD from a purely biomedical construct, to one that is more holistic involving a more 'bio-psycho-social' conception (BPS, 2000). This will be considered further in the next section.

Finally at the time of writing, recent findings from the MTA study (Jensen et al, 2007) were released which caused further controversy because the findings indicated that medication had no greater long term effects compared to behavioural treatments. This was a significant finding in relation to current treatment protocol which has tended to favour such medications. This was the subject of a recent topic in the media on the BBC's *Panorama* programme entitled: *What next for Craig?* (12 November, 2007). In this programme some of the co-authors of the MTA study were interviewed about the implications of the new findings. The following is reproduced from the BBC's transcription which is available in the public domain:

> **BBC Interviewer Jofre**: When I first met Craig Ritalin was considered a more effective treatment than behavioural therapy. The evidence for this came from an American research project that compared the two. Called the MTA study it looked at 600 children over a year and was carried out by some of the world's top experts on ADHD.

Dr Peter Jensen (MTA Study Co-author): We did the best study that's ever been done on Planet Earth, helping parents and teachers with these children – and what did it show? It showed that medicine was still a great deal more effective for these children.

Jofre: The MTA study was clear. For children like Craig, drugs worked better than therapy. The findings, shaped the way doctors worldwide treated ADHD.

Dr Tim Kendall (Royal College of Psychiatrists): It was big study and because its initial findings were that medication was as good as, if not superior to, any combination treatments, I think people have relied more on medication as a result of it, and ignored psychological treatment.

Jofre: Since the MTA conclusions were published, prescriptions for ADHD drugs have more than tripled in Britain. The Department of Health doesn't know how many of our children are on these drugs but we've discovered nearly 55,000 were prescribed them by their GPs last year alone. The cost to the NHS was 28 million pounds but are they actually helpful in the long term? Seven years on I've come back to the US where the experts have continued to monitor the 600 children in the MTA study. They've looked at what happened to the children who stayed on drugs for three full years and the results have come as a surprise even to them.

Professor William Pelham (University of Buffalo, MTA study Co-author): The children had a substantial decrease in their growth rate, so they weren't growing as much as other kids, both in terms of their height and in terms of their weight. And the second was that there was no beneficial effects – none. I think that we exaggerated the beneficial impact of medication in the first study. We though that children medicated longer would have better outcomes. This didn't happen to be the case.

Jofre: Until now parents concerned about putting their children on medication have been reassured that the benefits far outweigh any risks. These new findings call that advice into question.

Professor William Pelham: There's no indication that medication is better than nothing in the long-run. In the short-run it will help the child behave better, in the long-run it won't, and that information should be made very clear to parents.

Jofre: We've got a generation of children who have been on these kinds of pills now for some time. What is the evidence that it's helped them?

Professor Pelham: There's no evidence that it's helped them.

Jofre: As simple as that.

Professor Pelham: It's as simple as that.

The implications of these recent findings on health policy for ADHD treatments remain to be seen. It was noted on the BBC website that the release of these findings received greater press coverage in the UK than it did in the USA.

Epistemological and Methodological limits with a Biomedical Approach to ADHD

From the above outline of this extensive field, it is clear that ADHD has been constructed as a biomedical entity through DSM classification systems. It is clear that the construct is shrouded in controversy, to do with its changing definitions and corresponding classifications systems such as DSM and ICD, which are likely to continue to change (e.g. Barkley, 2006a). Despite the extensive research into causal factors, treatments and prognosis, there are still no biological markers to distinguish ADHD as a discrete condition. Proponents of ADHD have argued, as illustrated above, that with greater scientific progress, particularly in the area of genetics and biochemical brain activity, greater technological advances will yield further breakthroughs in knowledge and eventually identify the biological anomaly underlying ADHD. This argument rests on an epistemology which depends on the notion of scientific progress which characterises positivist assumptions within the natural sciences and underlies Western medicine.

A further main controversy surrounding ADHD remains over the widespread use of psychostimulant medication to treat the condition (despite a lack of long term studies and indications of side-effects and non-response rates). Such medications appear within biomedical approaches as frontline treatments and, indeed, the very ADHD construct is virtually synonymous within the media with such medications as Ritalin. The above discussion highlighted how extensive research in the ADHD field has been devoted to the investigation of drug trials in order to demonstrate that effectiveness. It was also significant that, until relatively recently, such treatments were regarded as superior to other treatments in terms of effectiveness. The influential MTA study in North America was shown to influence health policy in the UK through NICE and SIGN guidelines. The implications of the recent findings from the MTA which espoused the limits of medication long-term, however, remain to be seen. Nevertheless, they are significant because it is the first time that the limitations with such medication treatments have been acknowledged in the literature. Parental dissatisfaction with medication-only approaches and public opinion about the stigma of such medication has also surely been influential in favour of multimodal treatment approaches. However, until recently, multimodal treatments had limited efficacy over medication-only approaches in the literature. While they tended to dominate current health policy guidelines for ADHD both in the USA and the UK, medication remained as a dominant treatment as highlighted above. Despite the widespread professional

adoption of the multimodal treatments even within biomedical perspectives there are professional disputes over ADHD. For example: in 2002 the 'International Consensus Statement for ADHD' by a group of scientists and professionals issued a consensual statement over ADHD regarding its causes and treatments in an effort to discredit the 'inaccurate portrayal' and 'myths' that were circulating about ADHD (Barkley et al, 2002). Instead it fuelled further controversy with 'A Critique of the International Consensus Statement on ADHD' published in 2004, similarly by a group of scientists and professionals, who were critical of those attempts to construct ADHD as an unproblematic biomedical entity and forestall debate (Timimi et al, 2004). Thus even within a biomedical framework amongst professionals, ADHD remains a controversial construct.

The limits of the biomedical approach rest largely on its underlying assumptions. Neglect of contextual issues such as the socio-cultural and historical context in favour of the focus on individual genetics is tied to this. This biological reductionism of the complexity of human behaviour underlies the contemporary Cartesian dualism which separates the individual from the social or the mind from the body, which is characteristic of Western medicine. Such approaches tend to reduce the study of the individual to biological components, according to a positivist epistemology which emphasises notions of scientific progress and objective study in order to ascertain the organic basis for the condition. Thus, the emphasis in the literature has been on quantification and classification in order to study such aspects as diagnosis, elusive aetiology and treatments. The lack of attention to social and subjective aspects in this area includes, most crucially, the failure to acknowledge that a diagnosis of ADHD rests on the subjective interpretation of the clinician (and depends on which classification system is adopted). Furthermore, as diagnosis rests on impairment in two settings (i.e. the home or the school), it also rests on subjective interpretation by parents and teachers in the assessment of 'problems'. Cultural and individual aspects relating to judgments of these behaviours is something which is considered as subjective bias, rather than as reflecting a more fundamental issue to do with the diagnostic process itself. For example, poor parental and teacher correlations on ADHD rating scales were accounted for as due to parental psychopathology, lack of teacher knowledge about ADHD and teacher disagreements with parents (Gordon, 2006). Further, cultural differences in the rating of 'problems' are highlighted, for example, in a recent study which showed that teachers in Greece viewed traits of hyperactivity more positively than they did

for the ‘inattentive’ or ‘combined’ groups of ADHD (Kakouros, Maniadaki and Papaeliou, 2004). Methodologically, the focus on clinical trials and quantification has resulted in a limited consideration of qualitative aspects relating to ADHD.

The Biopsychosocial Construction of ADHD

As highlighted above, with multimodal treatments there was a move towards seeing ADHD as a more bio-psycho-social construct as opposed to a purely biomedical construct. Engel’s (1977) biopsychosocial model of disease is useful here to define what is meant by such a conception. Engel proposed a multi-factorial model of disease based on systems theory, in which a range of factors interacted and contributed to any disease. These ranged from the biochemical basis and genetic basis to psychological aspects such as personality, stress and coping to various socio-cultural factors such as socio-economics, for example. This approach was seen as a challenge to the predominance of the biomedical approach which had largely tended to ignore the influence of the psychosocial in disease causation. With a range of chronic diseases increasingly affecting Western societies, this was seen as a more holistic approach to diseases such as cancer, coronary heart disease and AIDS in which lifestyle factors and behaviour were increasingly acknowledged (e.g. Ogden, 2000). Such an approach to disease was taken up enthusiastically by the social sciences, particularly new disciplines such as health psychology which focused on the contribution that psychological processes could play in promoting health and preventing disease. Underlying such approaches was the recognition that if various ’risk’ factors could be identified for disease then these behaviours could be targeted at a preventative level and health promoted. The biopsychosocial approach in health psychology entailed that psychological and social factors had as much to do with diseases such as cancer, coronary heart disease and AIDS, as did their more biological basis.

A model for Biology, Psychology and the Social in ADHD

A biopsychosocial construction has been proposed likewise for ADHD, particularly in the UK (e.g. Singh, 2001; Cooper, 2001) whereby a range of factors are considered to interact in any individual to bring about the condition of ADHD. Thus while an individual may have a biological propensity towards ADHD through genetics, only

through particular interactions with the environment would such biological propensity be expressed (e.g. through poor parental coping; low socioeconomic status). In this account of ADHD, psychological factors as well as the socio-cultural environment are given greater credence than they were in purely biomedical constructions. The two examples cited above that advocate a biopsychosocial approach to ADHD will be explored; both appeared in a 2001 edition of *Children and Society*. Cooper (2001) acknowledged that genetics and biochemical changes contributed to ADHD, while at the same time recognised the influence of psychological attributes such as stress and coping by the family, and the socio-cultural environment which enabled labelling such behaviour as 'ADHD'. In his critical review of the literature, Cooper maintained that a biopsychosocial approach to ADHD was appropriate, given the dominance and established 'neuropsychological evidence-base for AD/HD' (2001: 390). This model was based on the recognition that the psychological, social and cultural are inseparable features of the environment and which created propensities for biological expression or inhibition. Cooper called for a 'holistic approach to ADHD' (2001: 393) and for greater research into the 'social reality of this medical condition' (2001: 393). Singh's (2001) research review, although it took issue with some of Cooper's points about the established evidence-base for ADHD and it argued for a cultural consideration of medication taking as well as a critique of the critical perspectives for ADHD, also concluded with a 'holistic picture' (2001: 365) for ADHD which integrated biomedical as well as socio-cultural aspects. In essence then, in such a biopsychosocial approach, while a genetic basis for ADHD is important, the social environment is given greater influence in providing 'risk' or 'protective' factors for ADHD. The widespread acceptance of the biopsychosocial approach to ADHD, as mentioned above, is indicated by current health policy guidelines for ADHD. NICE (2000) and SIGN (2001) currently advocate that multimodal treatments for ADHD be offered as an intervention. The British Psychological Society's (BPS) guidelines for the treatment of ADHD (2000) maintain that a multimodal treatment is offered that includes multi-agency intervention.

It has been argued above that a biopsychosocial construction of ADHD, whereby a range of factors are considered to contribute to ADHD, fits appropriately with current multimodal or combined treatment packages for ADHD. If a range of factors are considered to interact in order to contribute towards ADHD expression, then it follows that a range of treatments or packages should be on offer for the individual child and which include: medication, behavioural interventions for child

and family as well as educational interventions. It was suggested earlier that unpopularity and controversy over medications may be somewhat alleviated by the change in rhetoric towards medication as simply a part of a much larger treatment package, as a possible but not an inevitable intervention. It is argued further that a biopsychosocial construction of ADHD means that ADHD appears as a more acceptable construct than the previously implied biomedical one. The recognition of the psychological and behavioural aspects as well as the social environment in ADHD makes the biopsychosocial approach much more popular, particularly in the UK which has tended to be more psychodynamic in orientation than North America.

Risk and Protective factors in ADHD

The role of the psychological and social aspects in ADHD has generally received greater research attention in the UK and Europe than in North America, which explains why such approaches have tended to be largely underrepresented in the literature within the dominant American influence. Generally Europe has tended to follow a more psychoanalytic and psychodynamic paradigm to account for behaviour, rather than the biomedical and behavioural approaches in North America. Based on this approach, family dysfunction is largely held to be accountable for ADHD or ADHD-type behaviour including such areas as: poor parental coping, aggressive discipline, parental psychopathology and marital problems. These factors are generally considered poorly understood, together with the role of gender, culture and the different subtypes of ADHD (Woodward, Taylor and Dowdney, 1998; Johnston and Mash, 2001). Pelham et al's (1998) review of the literature which found support for behavioural therapy for ADHD is also relevant here.

Although such aspects have been under-researched, the research that has been done in the field has tended to be incorporated into the biopsychosocial construction. These aspects have tended to be conceptualised as 'risk' or 'protective' factors for ADHD. Recent research in the area has found, for example, that maternal depression was a 'risk' factor for the development of later conduct problems in ADHD while positive parenting was considered a 'protective factor' (Chronis et al, 2007). Prenatal exposure to stress and smoking was found to be independently associated with later symptoms of ADHD in boys (Rodriguez and Bohlin, 2005). Lange et al (2005) found that parents of children with ADHD

compared similarly to a clinical group of parents with a child with a mood or anxiety disorder for higher stress, lower social support, poorer quality of life, deficits in family functioning and poorer parental satisfaction than normal controls. Further, the parents of children with ADHD had higher levels of authoritarian parenting style. The authors highlighted the greater psychological health problems of the parents with children with ADHD as well as the clinical group. Attachment theory has also been influential in such research on ADHD, for example the notion that early secure maternal attachment resulted in better outcomes for children in comparison to the ambivalent or avoidant attachment. Thus the emphasis has been on targeting problematic parenting styles and early interventions in this regard are seen as important (e.g. Ongel, 2006; Thompson, 2006). The mother-child relationship, particularly, has generally been considered to affect later outcome rather than causing ADHD. These social and environmental 'factors' which have tended to emerge from the research in this area have in essence indicated maternal depression, maternal smoking and stress, maternal coping, alcohol and drug use as being influential in the development of later problems associated with ADHD (Barkley, 1998). These factors have been able to be incorporated into a biopsychosical model for ADHD. In keeping with a biopsychosocial framework, for example, Thapar and Thapar (2003) considered environmental factors for ADHD as 'mediating and moderating the effects of genes' (2003: 228). Clearly what stands out from such perspectives are the role of parenting – particularly maternal factors – in mediating and moderating such genetic predispositions to childhood ADHD.

Multi-modal treatment approaches in ADHD

Psychostimulant medication for ADHD remains an intrinsic component of the treatment for ADHD in the multi-modal 'package'. Below, other areas which may make up the treatment package are considered. The role of parent support groups are also discussed in view of the important role that they play for gaining support for other services and the often political role they that play.

Parenting and behavioural management: The emphasis in this area has been on targeting parenting styles and promoting early interventions in this regard (e.g. Ongel, 2006; Thompson, 2006). As highlighted above, Pelham et al's (1998) review showed that cognitive behavioural therapy for the child was not effective for ADHD

while contingency management was more effective. Parenting management styles have largely been the focus in such behavioural interventions for ADHD as well as regarded as being a 'risk' factor for the child's later behaviour. For example, Thompson (2006) emphasised a biopsychosocial approach to ADHD including genetic predisposition, prenatal influences such as stress, smoking and brain injury, as well as social factors to do with parenting, diet or toxins. The importance of the parent-child relationship and early positive parenting was emphasised here, drawing from Fonagy's (1998) stress of the importance of early attachment and its relationship to later conduct disorder. Positive parenting was characterised by: responsive parenting; praise; mutual co-operation; clear boundaries; consistency in limits; and kindness to the child. Coercive parenting, by contrast, was characterised by: negative parenting and blaming child; coercive efforts by both parent and child; conflict; child as an unequal partner; and being draining. One such parenting programme developed was the 'New Forest Parent Package' (e.g. Sonuga-Barke, Thompson, Daley and Laver-Bradbury, 2004) based on social learning theory and the notion that as behaviour is learned, it can be changed. Such programmes include an eight week programme focused on: psycho-education, the mother-child relationship, behaviour training with the child as well as training in attention and delay restructuring. In this perspective the parents are conceptualised as 'trainers' for later childhood behaviour (Thompson, 2006).

Barkley's (2005) *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents*, outlines eight steps for parents to manage their child with ADHD. These include: paying positive attention to the child; using powerful attention to gain compliance; giving more effective commands; teaching the child not to interrupt parent activities; setting up a home token system; punishing misbehaviour constructively; expanding time-out sessions and learning to manage the child in public places. Consistent with this approach, Barkley (2006a) maintains the parent as 'shepherd' metaphor for parents of children with ADHD which invokes the parent as important in managing rather than contributing to the child's ADHD. This distinction is significant and contrasts with Thompson's (2006) emphasis on the importance of the parent-child interaction outlined above. This was a point of controversy between the researchers at the 2006 Royal Society's of Medicine's Paediatrics and Child Health Section's conference entitled: 'Behaviour problems in children'. The main departure between the researchers was Barkley's (2006a;

2006c) refutation of the role of the environmental or social influences in causing ADHD due to a lack of evidence-base.

Educational management: Tied to such 'risk' and 'protective' factors as psychological and social influences in ADHD, the importance of the educational environment is key. Educational guidelines for teachers which provide knowledge and suggestions for ADHD are increasingly devised. For example: *ADHD: Attention deficit hyperactivity disorder: a guide for UK teachers* (2004) which offers various practical advice. These include working with the psychologist to: consider the classroom layout and the demands of the task; focus on specific activities the child has difficulties with; applying a consistent approach; various 'time out' and rewards systems (Based on the European clinical guidelines for hyperkinetic disorder first upgrade, Tayler et al, 2004). Cooper and O' Regan's (2001) *Educating Children with AD/HD: A Teacher's Manual* is more extensive and provides knowledge about ADHD behaviour symptoms and strategies for teachers to adopt for classroom management. Such interventions for teachers are usually multi-modal and consider effective principles for classroom practice.

ADHD Parent Support Groups: Various support groups for ADHD exist. These are mentioned here because of the role that they may play in providing parents with a forum for education about ADHD and support for managing the child's behaviour as well as information for further advice and information. Often there may be a political role that these groups play. For example, Cohen (2006) highlighted how CHADD or Children and Adults with ADHD, was an international lobby group that received funding from and collaborated with pharmaceutical companies in order to disseminate knowledge about ADHD. The charity ADDIS (ADHD information services) seeks to provide information and support for ADHD and is also involved in political lobby in the UK. A 'National ADHD awareness week' was held in 2006 including a media campaign called: *ADHD is real*. General campaign objectives sought to highlight inaccurate media portrayal of ADHD and provide greater national awareness of ADHD. Similarly, a national conference in 2006 in collaboration with various ADHD support groups in the UK launched a national campaign entitled: *ADHD Enough's Enough!!* The campaign sought to lobby for government changes to provide greater resources and recognition of ADHD. This was symbolised by

wristbands. Central to these movements is the notion that ADHD is under-diagnosed and under-treated in the UK.

Epistemological and methodological limits with a Biopsychosocial approach to ADHD

Research from a biopsychosocial approach to ADHD has tended to quantify the psychological and the social environment as 'variables' in order to compare and measure it with the biomedical aspects of ADHD. There are problems with this approach which will briefly be considered in relation to one of the above findings. The finding that prenatal stress and smoking was associated with later ADHD by Rodriguez and Bahlin (2005) may be critiqued when subsumed into a biopsychosocial model in its approach to broader social and economic aspects involved. From a critical health psychological perspective, the critique is not that the authors did not consider such environmental factors at all. However, the very notion that social and environmental influences can be isolated, quantified and measured against other independent and individual 'variables' or treated as 'confounding variables' is considered reductionistic. Against this quantification paradigm, an alternative approach is one which recognises the complex, interwoven nature of social reality and how social processes shape experiences in health and illness. The notion that 'undesirable' individual behaviour with regards to health can be targeted appears limiting from this perspective. For example, smoking as a 'risk' factor for health (to self and unborn child in pregnancy) has been critiqued as simplistic. Graham (1998: cited in Crossley, 2000) showed that working class mothers used smoking as a means of protecting their children from the harsh realities of poverty because they had few coping mechanisms available. Such research cautions against the simplistic focus on eliminating undesirable 'risk' factors for ADHD (i.e. such as smoking and stress) without considering the broader environment of poverty in which these behaviours occur. Arguably broader contextual aspects such as poverty are interwoven with such individual 'factors' as smoking and stress.

Tied to the above, in his review of the literature on ADHD, Rafalovich (2001) argued that neurological or biomedical explanations tended to dominate the literature and that while there were a range of psychological theories on offer for ADHD it was only those psychological theories that could be incorporated within the biomedical theories for ADHD that have been given research attention.

Psychodynamic theories for ADHD, by contrast, which have tended to challenge the biomedical construction with their focus on the family system, as opposed to the individual child, have not tended to feature prominently in the ADHD literature. The biopsychosocial construction of ADHD, then, may be accused from this perspective as a means of subsuming psychological and social theories into the biomedical. While the contribution of the biopsychosocial approach towards ADHD was clearly an attempt to bring psychological and social factors to greater attention than before, it has epistemological limitations as intimated above. It may be critiqued following more general critique of the biopsychosocial model such as found in critical health psychology, for example, which is considered further below for its applicability to the ADHD field.

Critical health psychology, which drew from critical social and clinical psychology (e.g. Yardley, 1997; Crossley, 2000; Murray and Chamberlain, 1999; Radley, 1994; Stainton Rogers, 1996) has highlighted problematic aspects associated with a biopsychosocial model of disease. Following such work there are a number of limitations for ADHD which may be levelled at the biopsychosocial approach. Such limitations include the tendency to study the realm of the psychological and social in terms of the biological. This biological reductionism relates broadly to the tendency within such approaches to translate the realm of the psychosocial into quantitative psychosocial 'variables' in order for them to be directly compared and measured with biological variables. Although the benefits of this tendency are clear, in order to win acceptance in biomedical areas for the contributions of psychological and social aspects to disease, it is not without limitations. The psychological and the social have been reduced to quantifiable variables and expressed in terms of the biological, rather than studied in their own right (e.g. Yardley, 1997). Critics have highlighted how such biological reductionism has meant that there is an increased need to study the realm of the psychological and socio-cultural aspects to health on their own terms (Yardley, 1997; Murray and Chamberlain, 1999). One such neglected area, for example, is what Crossley (2000) sees as a move from the more 'scientific' approaches within health psychology towards a more 'hermeneutic' approach which focuses on greater understandings of the experiences and meanings of illness. Qualitative research methods are more suitable for this form of analysis and this remains a neglected area in the field of ADHD.

These criticisms are not merely methodological however. While biopsychosocial approaches may consider socio-cultural and historical influences for disease by reducing them to 'variables' which impact on the individual, the scope of such influences are limited. The broader political, socio-economic and cultural structures involved in disease are not invoked unless insofar as they can be demonstrated to affect the individual. Also, although a multi-factorial model is proposed for disease the exact workings of the interaction are poorly understood in biopsychosocial models and the various factors often appear listed without coherence as to how they operate in any integrated fashion. The relative strength or impact that these variables have in comparison to one another is also not given scope in this model. Crossley (2000), following Radley (1994), argues that what is missing in these models is an appreciation of wider cultural aspects involved in both health and illness. That for example, illness has a moral dimension to it, with health being a 'dominant cultural motif' in contemporary societies (as seen in the rise of preventative measures and health maintenance regimes). The moral dimension of health espoused by Radley (1994) maintains that an identity as a 'good person' is constituted by an individual's health status and relationship to the 'good life' and that illness therefore is not merely the presence of disease but an implied reflection on one's sense of personhood. Ogden (2000), as a proponent of health psychology, concedes that the traditional Cartesian mind-body / individual-society dualism is maintained in traditional health psychology and the biopsychosocial model. Thus, rather than challenging a biomedical framework for disease, traditional health psychology and the biopsychosocial model maintains such individuo-centred and acontextual assumptions.

These general criticisms have significant implications for a biopsychosocial construction of ADHD. Following Rafolovich (2001), it is argued that a biopsychosocial construction of ADHD does little to challenge the traditional biomedical construct but instead incorporates aspects of the psychological and social within its framework. For example, while the biopsychosocial construction entails the interaction of biochemical, genetics, psychological vulnerability, behavioural patterns and socio-cultural variables which are recognised as important in ADHD, how they occur in any individual is poorly understood. Similarly socio-cultural aspects such as socioeconomic status and poor living conditions are reduced to 'variables' which compete with (equal?) magnitude as the biochemical basis or genetics for ADHD. These nearly always privilege the individual child which

remains, as in the biomedical construction, as the site of psychopathology. Those approaches that do consider other influences nearly always reduce the focus on the maternal-child relationship, at the expense of wider aspects. In addition, there may be moral dimensions of ADHD which should be explored further. As highlighted above, there is also a lack of research from a qualitative perspective which considers aspects such as the experiential basis of the condition in favour of the quantitative focus in the research. In essence, it is argued that the biopsychosocial approach to ADHD maintains a form of biological reductionism inherent in the biomedical approach due to similar dualist separation of the individual from the social. Ultimately these approaches are limited for ADHD. Finally, the biological emphasis in these approaches explains why, despite stress on treatment 'packages' for ADHD, that medication treatment is nearly always privileged as 'essential for most cases (not all)' (Barkley, 2006c).

Alternative and Complementary Constructions of ADHD

In addition to the dominance of the biomedical and biopsychosocial constructions of ADHD, other approaches to ADHD exist. These tend to remain on the fringes of the dominant approaches and are often dismissed as unscientific due to a lack of evidence-base for ADHD; however, they remain popular choices for parents. An overview is presented below.

Alternative and Complementary Approaches to ADHD

Alternative and complementary approaches to ADHD are extremely varied with many using a 'holistic' approach. Inherent within these approaches, a holistic approach to ADHD appears in stark contrast to the holistic approach of the biopsychosocial approach. Rejecting individual notions of psychopathology, these approaches often consider various holistic systems as involved in health. There is a vast array of alternative approaches which may come under the rubric of alternative/complementary such as: dietary elimination or modification, food supplements such as fish oils, homeopathy, biofeedback techniques, Chiropractic Skull manipulation, brain gym, etc. There remains an extensive alternative and complementary market for ADHD with a wide range of options available and made accessible through the greater use of information technology. The relevance of

alternative and complementary approaches to ADHD was highlighted by a study by Bussing et al (2002) which found that parents of children with ADHD or of suspected ADHD were more likely to make use of alternative treatments than parents of children with more general behavioural or emotional problems. The work also highlighted how parents tended to dislike mainstream medication approaches. The SIGN (2001) guideline does not advocate such treatments as a matter of course indicating the lack of evidence-base for such treatments. However, clearly the popularity of alternative and complementary approaches – like in other areas of consumerist healthcare which exists as an alternative to mainstream medicine – means that parents may choose these approaches regardless of their evidence-base and often as an attempt to seek an alternative to psychostimulant medication. This section will not be exhaustive in the review of alternative and complementary approaches, but will highlight an area deemed promising in the literature.

An example: The Cactus Clinic

An example of such alternative approaches to ADHD is the work of the Cactus Clinic (University of Teeside, in Middlesbrough, UK). Woodhouse (2004) outlines the alternative approaches offered at the Cactus Clinic as: a drug withdrawal programme, a caregiver's skill programme and an individual nutritional assessment guidance programme. An extensive cognitive programme is developed for an individualised educational programme as required. Approaches such as the Cactus Clinic offer alternatives to medication approaches which tend to characterise routine services in the NHS and focus on information, treatment and research of these alternative approaches.

Nutrition and ADHD

Diet is an area of research that has received increasing attention for ADHD. Schnoll, Burshteyn and Cea-Aravena's (2003) review indicated that the nutritional aspects in ADHD had been neglected to date and that work in nutrition had advanced since the discredited research in the 1970s and 1980s which implicated additives such as Tartrazine in causing hyperactivity (Feingold, 1975). The authors argued that individual dietary manipulations should be considered as part of treatment packages

for ADHD as individual differences in deficiencies, food intolerances, additives and fatty acid deficiency may be implicated in ADHD-type behaviour. Such research is against the notion of an individual 'offending substance' for ADHD in favour of individual dietary considerations. Of current and growing interest has been research in the area of fatty acid deficiency. For example: recent research has argued that fatty acid metabolism was involved in ADHD (Richardson and Puri, 2000) as well as ADHD, dyslexia, dyspraxia and autistic behaviour (Richardson and Ross, 2000) as symptoms of fatty acid deficiency could be found in children diagnosed with ADHD. Harding, Judah and Gant (2003) showed the benefits of a dietary supplement for children with ADHD which was comparable with treatment with Ritalin. Finally, the area of omega-3 fatty acid supplements for ADHD and related conditions is considered important to promote healthy brain functioning. Adequate intake of omega-3 through fish is considered insufficient in ordinary diets and thus there is an increasing emphasis of providing supplements of fatty acids. The promotion of these supplements is recently seen in ADHD support groups, ADHD conferences as well as the media and recent research area in this field. The relationship between antisocial behaviour and nutritional supplements was boosted by a study which demonstrated improvements in antisocial behaviour in prison inmates after such interventions in diet (Gesch, Hammond, Hampson, Eves and Crowder, 2002). Although promising, such research is currently under-developed and focused on building an established evidence-base in which to challenge the dominant biomedical medication focus.

Epistemological and methodological limits of Alternative and Complementary approaches in ADHD

Within health policy and treatment guidelines for ADHD, greater evidence-based research is emphasised for diet and the various alternative and complementary therapies, before such treatment can be established or recommended. The use of randomised controlled trials to establish evidence-base in such alternative approaches has often been regarded as problematic for the alternative therapies (e.g. for use in homeopathy). This does mean, however, that such approaches appear to be under pressure to produce 'evidence-based' findings in order to compete with medication. While the contribution of a holistic approach to children's

attentional difficulties clearly has the potential to challenge a biomedical approach, it is argued that they exist largely as alternative *treatments* rather than as alternative *conceptualisations* for health and ADHD. Such approaches remain as popular choices for parents of children with ADHD diagnoses, despite a lack of support by current health policy for alternatives to medication. However, similarly to a biopsychoscial approach to ADHD, challenge of the biomedical construct of 'ADHD' remains limited. For example, Malacrida (2002) examined textual data relating to alternative and complementary therapies and ADHD, obtained from local sources in Canada as well as international sources. Her analysis of the material highlighted that rather than challenging the dominant biomedical approaches, these approaches tend to emphasise the prevailing assumptions within such approaches. This parallel rests on a similar emphasis on maternal inadequacy and responsibility for the child, emphasising the child as at 'risk' and as a potential danger to society, and stipulating an extensive and elaborate network of alternative causal pathways. This means that there was an increased range of possibilities for parents to be implicated in the child's difficulties. Thus, alternative and complementary approaches do not challenge the biomedical construct of ADHD, they emphasise individual responsibility, are gendered as they typically invoke maternal influences and similarly require professional intervention. These underlying assumptions parallel the dominant biomedical approaches rather than offering a serious challenge.

Conclusion

This chapter has outlined the dominant approaches to ADHD as a biomedical approach, and increasingly a biopsychosocial approach in the UK. Despite different emphases and allowances of the role of the psychological and social influences in ADHD through the biopsychosocial approach, it was argued that both approaches have tended to privilege the role of biomedical aspects and so a form of biological reductionism remains. Essentially, limits of epistemology associated with these approaches have originated from the positivist emphasis on scientific progress and entailed a methodological emphasis on quantification and clinical drug trials. It was argued that the realm of the 'psychosocial' in ADHD has therefore been neglected and reduced to associated variables. Qualitative experiential aspects of ADHD, by comparison, have been neglected in the research, as have broader socio-cultural and historical aspects surrounding ADHD which have remain obscured. While alternative and complementary approaches to ADHD and children's difficult

behaviour may have the potential to offer different conceptualisations of this area and so challenge the dominant biomedical one, it was argued that they were also limited. Alternative and complementary approaches to ADHD largely exist as providing alternative treatments and are under pressure to provide 'evidence-based' research under current guidelines. Essentially such alternative and complementary approaches have also been limited in terms of challenging the dominant assumptions underlying the ADHD construct. In light of the limitations of the approaches outlined here, the following chapter turns to a consideration of the limited qualitative research that has been conducted in the area of ADHD and parental subjective experiences.

Chapter 3: Parental Subjective Experience and ADHD: A Qualitative Review

Introduction

This chapter focuses on the neglected area in ADHD, of parents' subjective experience of their child's diagnosis of ADHD. The chapter is divided into two sections. The first section consists of a review of existing studies which have focused on parental experiences and ADHD. A thematic consideration of the similarities and differences across the studies was adopted in order to consider the wider field. Ten studies were included in the review from different cultural contexts and which deployed different methodologies. Common to these cultural contexts, however, was the classification of children's difficulties as ADHD. The review and synthesis of the findings was interpretive and highlighted common themes about parental experiences of ADHD from the different studies. In the second section of the chapter, a critique of the existing literature was offered comprising methodological as well as epistemological limits. Underlying the studies in the review was essentially a common humanist epistemology which tended to privilege parental subjective experience and which redressed the balance of the literature in terms of understandings of such qualitative aspects for parents. Limits with this approach, however, were discussed in relation to the dualist focus on the individual and which necessarily resulted in a limited capacity to focus on social practices and processes in ADHD. Language about ADHD has tended to be treated as a resource for gaining access to underlying subjective experiences rather than as a topic in its own right. Talk about ADHD is significant and can be construed as a discursive topic which is available and used in localised, everyday contexts in order to constitute experience. This has been a neglected area in the research and an argument was made for a discursive approach to ADHD as an alternative approach to individual subjective experience.

Background to the Qualitative Review

In light of the research that has been conducted into aetiological, prognostic and treatment modalities for ADHD (as reviewed in chapter 2), qualitative research into the psychological and social aspects such as experiences of ADHD has been

neglected by comparison. Parents of children with ADHD are a particularly important group because they may make decisions regarding identifying difficulties in their child, and also about treatment and care. As was seen in chapter 2, a diagnosis of ADHD depends on impairment in two settings (i.e. at home and school) and therefore diagnoses of ADHD rests on parental perceptions (as well as school perceptions) of problems to a large extent. Little work to date has focused on the qualitative experiences of ADHD for parents. Considering the rising incidences of ADHD in the UK, for example, this neglect appears significant. Qualitative research about parental experiences of ADHD is important to inform practice and policy for ADHD because it provides valuable understandings of the experiences of the recipients of such policy and practice.

During the phases of writing up the thesis, the author came across a metasynthesis of mothering other-than-normal children by Nelson (2002). Noblit and Hare's (1988) version of meta-ethnography and reciprocal translation was used in that metasynthesis in order to examine the literature on mothering children with various disabilities. Noblit and Hares' (1988) metasynthesis method essentially involved a consideration of individual studies in terms of the original language used, and the 'translation' of the findings from the studies into common 'metaphors' across the studies. 'Reciprocal translation' occurs when the studies are about similar topics. In Nelson's (2002) metasynthesis, studies reflected a range of methodologies and a range of children's disabilities (i.e. ADHD, asthma, schizophrenia, cerebal palsy etc.). All the studies included in that synthesis appeared to come from a North American cultural context (some were unspecified) and published in the 90s. The one study that had dealt with mother's experiences of their child's ADHD was Segal's (1994) doctoral dissertation. As Segal's (2001) published findings had already been included in the present review, no revisions were made to the present synthesis. Nelson's (2002) metasynthesis was a useful consideration of the general field of mothering children with disabilities and is further discussed below in relation to the findings of the present synthesis. Nelson (2002) had synthesised such disparate disabilities because of an inability to locate studies which had focused on a single condition. The present review therefore, is a focus on the single condition of ADHD because it was possible to locate a number of studies which focused on ADHD. Unlike Nelson's (2002) synthesis, however, the present review focused on published research (i.e. half of the studies in Nelson's synthesis included unpublished doctoral dissertations). In addition, the present synthesis focuses on

parental experiences rather than mothers only. This is in keeping with the original study aims which reported on parents' experiences (Segal, 2001, appears as the exception here as it focuses exclusively on mothers). Nelson's (2002) synthesis outlined four steps in mothering a child that was other-than-normal including: becoming the mother of a disabled child; negotiating a new kind of motherhood; dealing with life as it would never be the same again and finally the process of acceptance/denial of the disability.

In the area of ADHD there is limited work focused on qualitative experiences. Conrad's (1976/2006) classic study was an influential illustration of the sociological process of the medicalisation of deviant behaviour in the area of identifying children for hyperactivity. The relevance and contribution of this work is evident in the publication of an expanded edition in 2006 of the work and its classic challenge to a medical construction is still influential in this area. Conrad's (1976) original empirical study focused on children referred for hyperactivity at a specialist clinic in North Eastern USA. This work, along with other recent sociological contributions such as Malacrida's (2001, 2003, 2004) cross comparative work with mothers of children of ADHD and Rafalovich's (2001, 2004) extensive work, have provided a distinctive critical contribution towards ADHD and as an example of the labelling of deviance in society. This largely critical perspective towards ADHD as socially defined and constructed, along with a different stance taken towards language, is seen to be due to a radically different epistemology to the studies in the review. The contribution of such work, along with its epistemological roots, is the focus of chapter 4 and is not reviewed here because of such intrinsic differences of epistemology to the current review. Thus the focus of the present review was concerned with parental subjective individual experience and ADHD.

A Description of the Studies

The studies included in the review comprised published work in English. Studies were included if they addressed parental qualitative experiences of ADHD and used a qualitative methodology to study this area. The focus on individual parental subjective experience for ADHD reflected the common underlying epistemological position of humanism. The following ten studies were included in a review of existing qualitative research (see TABLE 1 below).

TABLE 1: QUALITATIVE STUDIES INCLUDED IN THE REVIEW

Parental Experiences of their Child's ADHD

STUDY	ORIGIN	AIM	METHOD*	SAMPLE
1. Harborne, A; Wolpert, M & Clare, L (2004)	UK	Parents' aetiological models & individual experience of ADHD	GT; 10 interviews with parents	Health database; 9 mothers, 1 father with child 9-11 yrs
2. Bull, C & Whelan, T (2006)	Australia	Common schemata guiding management practices of ADHD	IPA; 10 interviews with mothers	ADHD support group; 10 mothers
3. Klasen (2000)	UK	Experiences and agency of parents with GPs for ADHD	Grounded Hermeneutics; 29 interviews with parents (& 10 GPs)	Parent support (medical & holistic), community & specialist clinic groups; 19 mothers, 1 father, 9 both parents, 10 GPs.
4. Kendall (1998)	USA	How parents experience & cope with ADHD	GT; interviews with 15 families	Health clinic, parent support, school, community health; 15 mothers, 10 fathers, child 6-18 yrs
5. Singh, I (2003; 2004)	USA	Mothers' & Fathers' experiences with ADHD diagnosis & treatment	GT; 39 interviews with mothers & 22 with fathers	Clinic and non-clinic; 39 mothers, 22 fathers.
6. Neophytou, K & Webber, R (2005)	Australia	Experiences of families for ADHD	Thematic analysis; 3 case studies	Hospital screening; 5 interviews each.
7. Segal, E (2001)	USA	Experiences of mothers for ADHD	GT; 25 interviews with mothers	CHADD ADHD support group; 25 mothers.
8. Hansen, D & Hansen, E (2006)	Canada	Experiences of parents for ADHD medication	Phenomenological; 10 interviews with parents	Child psychiatrist and advocacy group; 9 mothers, 1 father.
9. Bussing, R & Gary, F (2001)	USA	Parents' evaluation of treatments for ADHD	GT?; four focus groups with mothers/ female carers	School screening for special education; 25 mothers (13 Caucasian & 12 African American)
10. Taylor, M; O'Donoghue, T & Houghton, S (2006)	Australia	Parents' experiences with decisions for ADHD medication	GT; 33 interviews with parents	University database and support groups; 28 mothers, 5 fathers.

*GT: Grounded Theory; IPA: Interpretive Phenomenological Analysis

As can be seen from TABLE 1, a range of different methodologies were used and included: Grounded Hermeneutics, Grounded theory, Interpretive Phenomenological analysis, Phenomenological analysis and thematic analysis. Studies were recent in order to reflect on recent experiences as defined as ADHD. The oldest study was published in 1998 (Kendall); although Segal (2001)'s published research came from interviews conducted in 1992-1993. In addition the studies reflected countries in the USA, Canada, UK and Australia. Studies were reviewed in terms of their main aims and methodologies for selection. Although the aims of the studies were disparate, reflecting different theoretical points of departure as outlined above, the studies were included in the review if the underlying broad aim was to address parental experiences of ADHD. Parents as the focus of the review were deemed important because of the central role that they play in the identification of potential difficulties in the child and management for ADHD. While it is acknowledged that others groups may also be significant to study, the review found very little work which considered other relevant groups in a sufficiently detailed fashion in order to constitute a review. As highlighted earlier, work from a radically different epistemology to the review was considered in chapter 4 and deemed to warrant separate attention. This epistemological stance included studying ADHD as socially constructed and with a focus on language and discourse. Finally the search strategy for the review considered qualitative research about "ADHD" as well as "hyperactivity" and "ADD" as its search terms in view of the varied nomenclature in this area. In addition while the review attempted to be exhaustive in its search for relevant studies, it is acknowledged that there may have been recent studies that were missed. For example, Blum's (2007) work is included in the later discussion. The search strategy involved searching relevant databases and the references of previously published qualitative research in the field; the difficulties of retrieving relevant published qualitative research has been reported elsewhere (e.g. Dixon-Woods et al, 2006). The numbers included here, ten studies, were deemed sufficient to warrant a review of the area.

Method used in the Review

In light of the similar epistemological position adopted by the studies as well as the different qualitative methodologies which were employed in the review, it was deemed appropriate to consider the findings across studies thematically. During the

thematic comparison of the findings, the following strategy was adopted: the main findings were listed for each study separately in the original study terms; they were then compared with the findings of other studies in order to reveal similarities and differences. In this manner it was possible to reveal several main themes that emerged from the review. The method adopted had much in common with other methods in qualitative analysis such as the constant comparative method. In addition, it had similarities to the reciprocal translation method from Noblit and Hare (1988). In considering the findings from the studies in the review, additional and related work was also consulted as deemed relevant (i.e. Klasen and Goodman, 2000; Kendall and Shelton, 2003). The common findings from the review will be considered below as discrete themes although they were not mutually exclusive. The review findings are summarised in TABLE 2 below.

TABLE 2: TABLE SHOWING SUMMARY OF MAIN THEMES

Parental subjective experience and ADHD

STUDY	AIM	THEME
1. Harborne, A; Wolpert, M & Clare, L (2004)	Parents' aetiological models & individual experience of ADHD	**Having different views** **'Blame'** **'Battles'** **'Emotional distress'**
2. Bull, C & Whelan, T (2006	Common schemata guiding management practices of ADHD	**Schemata: child is 'different'; 'parental aspirations'; 'needing medication': mixed; psychological management; 'parent authority'; role of father'; role of mother': stress, 'total personal responsibility'; lack of 'community support'**
3. Klasen (2000)	Experiences and agency of parents with GPs for ADHD	**'Clashes' with GPs over views & help** **'family experiences' as blame & stress** **Mixed over diagnosis**
4. Kendall (1998)	How parents experience & cope with ADHD	**'Outlasting disruption' via: 'making sense': stress & exhaustion; 'recasting biography': grief & guilt & blame; 'relinquishing good ending': different view; depression; Mixed about medication**
5. Singh, I (2003; 2004)	Mothers' & Fathers' experiences with ADHD diagnosis & treatment	**Fathers different views: 'reluctant believers' or 'tolerant non-believers'** **Mothers: 'brain' blame; blamed by father etc.; mixed over diagnosis & medication**
6. Neophytou, K & Webber, R (2005)	Experiences of families for ADHD	**Stress for mothers** **Blame prior to diagnosis; different views** **Mixed about diagnosis** **Mixed about medication**
7. Segal, E (2001)	Experiences of mothers for ADHD	**'No delay' (battled school) vs 'Long delay' mothers** **'stress and grief', 'guilt' reactions** **'Learning new ways' of mothering**
8. Hansen, D & Hansen, E (2006)	Experiences of parents for ADHD medication	**Medication 'dilemmas:'** **'Side-effects' vs 'functional effects' at school** **'Long term worries' vs 'goals for future'**
9. Bussing, R & Gary, F (2001)	Parents' evaluation of treatments for ADHD	**Medication dilemmas for parents vs practice guidelines** **Alternative & other 'home-care' treatments** **Not liking medication**
10. Taylor, M; O'Donoghue, T & Houghton, S (2006)	Parents' experiences with decisions for ADHD medication	**Medication 'dilemmas'** **Decision making: 'grieving': emotional distress & remorse; 'cynicism' over society views; 'doing right by my child': proactive parenting**

Themes from the Review

The findings of the review are represented by the summarised themes shown in TABLE 2 above. These themes are reflected in the language of the original studies and so reflect the interpretive aims of the review. The themes are discussed below as discrete, highlighting similarities and differences between studies where appropriate. However, there was also considerable overlap between themes. Five themes were delineated from the review including: holding different views about ADHD; parental blame and responsibility; experiencing battles about the difficulties; parental health problems and medication dilemmas.

1. Different views about ADHD

It was clear from the studies that parents held very different views about ADHD to others that they came in contact with. In the study by Harborne et al (2004), parents (predominantly mothers), held competing views about ADHD in which they tended to support a medical view of the child's condition. In this study further, the authors noted that: 'The issue of understanding the nature and causes of ADHD was therefore a key experience for the parents of this study' (Harborne et al, 2004:330). Similarly Klasen's (2000) study highlighted that parents held a predominantly medical view of hyperactivity as seen in:

> It's a chemical imbalance; it's this dopamine that is missing; his body doesn't make enough of it. It's like with diabetes, it's genetic.
>
> Reported in Klasen and Goodman, 2000, p.200

In contrast to this medical view, a competing view that poor parenting was an overriding explanation for the child's difficulties, prevailed amongst others such as fathers, extended family members, teachers and the public (Harborne et al, 2004) as well as general practitioners (Klasen, 2000). For example:

> My mother-in-law said 'do something about him, smack him and he'll be fine.' (1)
>
> Reported in Harborne et al, 2004, p.331.

> The GP and the consultant paediatrician said, 'Oh, he is just a typical boy', and of course you don't want to be seen as a mother who gets overanxious about things. If they say it is okay, it must be okay.
>
> Reported in Klasen, 2000, p.338.

However, in the study by Singh (2003), the author showed that a medical view about the child's condition was specific to mothers. Fathers, in comparison, were less likely to see the child's difficulties as a medical condition. Instead fathers would identify with their son's behaviours as 'boys will be boys'. Fathers tended to be 'reluctant believers' or 'tolerant non-believers' towards their child's condition as ADHD. This study was unique in separating out maternal and paternal experiences. An example of a father's perspective follows:

> I just thought he was – I had ants in my pants. I remember always being behind. It's just the way it was with me. I did crazy things as a kid. If you had tested me, you'd probably find I had some form of ADD. So I said to [my wife], 'Don't worry. He's fine.' I just figured [the boy] was the same as me. And I always pulled it out when I had to. I figured he'd do the same.
>
> Reported in Singh, 2003, p.312.

Neophytou and Webber (2005) too highlighted that mothers held different views about ADHD but that they seemed to vacillate over whether the child had a genuine condition. In the study by Taylor et al (2006), parents tended to be cynical about society's views regarding ADHD and the notion that the parent should control the child's behaviour (as well as its stance against medication to do this).

Thus it's clear that many of the studies showed that parents, particularly mothers, held medical views of their child's difficulties. They experienced others around them as holding competing views about the child's difficulties which involved poor parenting. Fathers appeared less likely to hold a medical view.

2. Blame and Responsibility

Parental experiences of blame and responsibility for the child's difficulties was also a common finding in the studies, particularly for mothers. This could be seen in relation to the nature of the competing views that the difficulties were due to poor parenting. In the study by Klasen (2000) parents felt blamed by their GPs over their child's hyperactivity (which is in keeping with the finding that the GPs did generally consider such behaviour to be the result of poor parenting). The two groups clashed

because of differences over causality: families saw the hyperactivity as causing stress in the family while GP's saw family dysfunction as causing the hyperactivity. Although mixed, a diagnosis was argued to be largely positive because it allowed a reframing of the child's difficulties in medical terms (i.e. from "badness to illness", Conrad, 1981; cited in Klasen, 2000), and allowed parents to make use of outside help and also improved relationships with the child. Kendall's (1998) work, like Klasen's (2000), also argued that parental blame and stigma was directly related to and lessened by a medical belief in ADHD. Further in Neophytou and Webber (2005), the authors also found that mothers experienced considerable self-blame prior to diagnosis, which tended to be relieved post - diagnosis.

Singh (2004) explored maternal experiences of blame directly and found that mothers tended to experience their mothering according to the 'good mother' motif. The 'good mother' was someone that was seen as understanding, protective, close, wise, selfless and lacking in conflict and this was a pervasive 'cultural motif' for experiencing motherhood. Further, mothers tended to self-blame if they did not succeed in managing their child. Like Klasen's (2000) study and Harborne et al (2000), mothers experienced blame from the wider community and from fathers. Singh (2004) argued that a diagnosis of ADHD reduced maternal blame (i.e. 'blame-brain' rather than 'mother-blame'), which paralleled arguments by others (Klasen, 2000; Kendall, 1998). However Singh's (2004) work, in contrast, argued that at post-diagnosis a medical explanation in fact reinforced notions of the 'good mother' ideology because mothers were still very much held responsible for the child's behaviour and management of ADHD. A medical explanation then, unlike Klasen's (2000) and Kendall's (1998) argument, did little to challenge maternal responsibility and blame which was entrenched in society. The limitations of a medical explanation, and its impact for parental blame and responsibility, were similarly espoused by Bull and Whelan (2006). Here the authors found that mothers had particularly high expectations of their roles as mothers and they experienced blame and stress over their child, taking on 'total personal responsibility' for the child. The authors argued, in a similar vein to Singh (2004), that while a diagnosis of ADHD was useful on a superficial level because it appeared to reduce parental blame, it was ultimately limited in terms of parental management strategies as reductionist. Alternative explanations and the impact of the social and physical environment were not given scope to account for the child's behaviour.

While Segal's (2001) work did not indicate maternal blame and responsibility in her work, her charge and challenge for mothers having to 'learn new ways of mothering' meant that their success or failure at learning such techniques could be gauged over management of the child's ADHD. This parallels scientific views on parental management techniques for the child's ADHD (e.g. Barkley, 2005) and could be said to imply a position of blame in Singh's (2004) terms over such success or failure with mothering techniques. Thus in Segal's work, the implication is that the 'long delay' versus the 'no delay mother' could be judged and held responsible over her ability or inability to successfully manage her child with ADHD. In Neophytou and Webber's (2005) case studies, the notion of the 'good' versus 'bad' mother was also significant, as in Singh's (2004) work. Lastly Taylor et al's (2006) notion of a parent that attempted to be 'doing right by my child' for treatment was emphasised. In the three decision-making stages over medication there were sub-stages which involved parental anger over their potential role in the child's difficulties and 'remorse' over poor parenting practices which indicated parental self-blaming as a feature.

Fathers in Klasen's study (2000), however, tended to be more ambivalent about a diagnosis. This finding was echoed in the work by Singh (2003; 2004). Amongst fathers both 'reluctant believers' and 'tolerant non-believers' tended to identify with their son's behaviour (as mentioned above). Paternal experiences of blame were not as widely reported as maternal blame and responsibility for children with ADHD. However, a few of the studies reported on fathers' experiences of guilt and shame. In Singh's (2003) study fathers who were 'reluctant believers' tended to feel shame over their son's behaviour when it impacted on their academic performance and/or sporting ability. Similarly Kendall and Shelton (2003) reported fathers' experiences of guilt and shame at the loss of a fully functioning family. These findings suggest that blame and responsibility for these fathers may also have been significant.

Thus, maternal experiences of blame and responsibility were a common feature in the studies when mothers came into contact with others that held competing views about the child's difficulties. This was held as a cultural motif in some of the studies. Fathers, other family members, health professionals, education staff and the wider community tended to view mothers as essentially responsible for their children and that the difficulties were to do with poor parenting practices. Findings with fathers however, suggested that while they had different experiences

to the mothers, they may not have been immune to experiences of blame and responsibility.

3. 'Battles' over differences

Everything is a battlefield. (7)

Reported in Harborne et al, 2004, p.332.

The implications of having different and contradictory views about the child's difficulties and experiencing blame and responsibility for the child's behaviour meant that parents were engaged in a number of struggles or 'battles'. As seen in the above quote, 'Battles' was a main finding reported in Harborne et al (2004) when parents came into contact with partners, in-laws and other family members, as well as teachers and health professionals. Klasen (2000) too indicated 'clashes' with GP's (as mentioned above) when parents came to the GP's with difficulties that they perceived in their child's behaviour. For example:

> You see no one understands, no one believes you. It's like smashing your head against a brick wall.
>
> Reported in Klasen and Goodman, 2000, p.200.

> My husband just doesn't understand the problem…he blamed me, so I ended up fighting him…We got caught up in a political discussion about whether the disorder exists or not…What the services didn't understand was that it was a question of having two children with hyperactivity that broke my marriage up and not the other way around.
>
> Reported in Klasen, 2000, p.337.

Similarly in Taylor et al's (2006) decision-making stages for medication, in the 'cynicism' stage, parents had to deal with different views about ADHD and medication from schools, family members and the public. Bull and Whelan's (2006) parents faced a 'lack of community support' over ADHD in gaining help and support. Segal's (2001) 'no delay' mothers were brought into conflict with schools when they tried to get help and recognition for their child's difficulties and were engaged in '*battling the schools*' for resources (Segal, 2001, p.269, emphasis original). Bussing and Gary's (2001) study highlighted how parents diverged from practice guidelines

for ADHD. As opposed to health guidelines, they used home-care strategies that were not evidence-based. In addition, they found the medication regime difficult to accept and like and this may have meant conflict with health professionals over issues to do with adherence.

Thus, 'battles' represent the struggles that parents experienced over competing views about ADHD with each other, other family members, schools, medical professionals and the wider community and in relation to gaining help and support for such difficulties.

4. Psychological and physical health problems

There was a widespread reporting of psychological health problems for parents as a result of their experiences with having a child with ADHD. This was particularly prevalent amongst mothers, but not exclusive to them. Harborne et al (2004) reported 'emotional distress' as a main finding of their study which ranged from depression, physical health problems, marital problems, a lack of sleep, anxiety and stress. Bull and Whelan's (2006) in their study of common parental schemas found that parents experienced considerable stress over the perceived discrepancy between having an atypical child and in conflict with their own aspirations for the child. This impacted on their marital relationships and health. Klasen's (2000) families experienced stress and in Kendall's (1998) 'making sense' stage, parents also experienced stress and exhaustion in their parenting. They also experienced depression when they were required to 'relinquish the good ending' (which was similar to Bull and Whelan's (2000) notion of unrealistic parental aspirations). Mothers in both Neophytou and Webber (2005) and Segal's (2001) work were found to experience stress and grief reactions. One of Taylor's et al (2006) decision-making stages over medication consisted of a 'grieving' stage which consisted of four sub-stages associated with health including: 'venting anger', 'emotional turmoil', 'remorse' and 'feeling depressed' which is likened to the emotional distress reported above.

5. Medication dilemmas: a 'balancing act'

Three of the studies directly studied treatment experiences for ADHD and Singh's (2003; 2004) work addressed this area as well. Experiences with the medication for ADHD appeared in these findings to be dilemmatic. Bussing and Gary (2001) compared treatment evaluations with professional practice guidelines for ADHD and found that the largest discrepancies occurred over medication. Although they did use the medications, parents found the medications difficult to use and accept and preferred behavioural techniques instead. This was in distinct contrast to the treatment guidelines which advocated medication as the main treatment. Hansen and Hansen (2006) similarly highlighted that parents experienced a 'balancing act' of weighing up the desirable versus the undesirable aspects of the medication. The dilemma rested on: the noticeable functional effects of the medication which allowed increased concentration at school versus the undesirable side-effects of the medication such as appetite loss and sleep loss. A further dilemma consisted of weighing up long term fears and worries about the child using the medication versus having goals for the child's future learning. Singh's (2003) work with fathers showed that they too had reservations about the medication, being less likely to think that the child needed it. However, they tended to be silent on these issues. Taylor et al (2006) also reported dilemmas about parental decision–making processes for medication. Here parents aimed to be 'doing right by my child' and moved through three stages of grieving, cynicism and proactive parenting, depending on the level of support they received. Parents in the grieving stage eventually reached a guarded acceptance of their child's ADHD and medication, after having tried various alternative therapies. They were cynical over society's attitudes towards medication and in the final stage, took on responsibility for administering the medication and educating others about ADHD. While Bull and Whelan (2006) focused on schemata involved in the management of ADHD, the authors also highlighted that the third schemata consisted of the parents coming to terms with the need for the medication, which was mixed with reservations. Kendall (1998) and Neophytou and Webber (2005) also indicated the medication as problematic for parents to come to terms with.

Thus, medication decisions appeared to be a mixed experience for parents. These experiences are represented by the metaphor in Hansen and Hansen's

(2006) ‘balancing act’ of the perceived need for the medication versus its undesirability for parents.

Discussion of the Main Themes

The review examining parental experiences with a child with ADHD highlighted five main themes across the various studies. Mothers tended to have a medical explanation for their child’s difficulties as ADHD which appeared in contrast to those of fathers, other family members, teachers, health professionals and the public at large. They perceived others as holding a competing view about poor parenting to be able to explain the child’s behaviour. The implications of this were profound, especially for mothers. Mothers took on greater responsibility for the child’s behaviour and felt blamed. The wider cultural notion of maternal blame was indicated by some of the studies, although fathers too may have been implicated in such blame and responsibility. Mothers too experienced considerable emotional distress (such as stress, anxiety, depression, marital problems etc.) and had to struggle in order to gain help and support for the child from schools, the community and from health professionals such as GPs. Treatment with medication was a mixed experience for parents which went beyond simple ‘pro’ or ‘anti’ stances. These findings from the synthesis are considered as best encapsulated by an extension to the metaphors from the work by Harborne et al (2004) including: holding competing views; maternal and paternal blame and responsibility; ‘battles’ against others; parental health problems and medication dilemmas.

Parental blame over a child that is seen as different is widely reported in the literature. For example, Harden (2005) showed how parents of young people with various mental health problems were similarly implicated in parental causal mechanisms and went through a process from being ‘deskilled’ in their parenting to ‘reskilled’ when they came to terms with the problem. There were similar parallels with battles that they faced with the medical profession in terms of being listened to and gaining support. In the metasynthesis by Nelson (2002), similarly, mothers had to negotiate a new type of mothering and they did this largely by dealing with society’s judgements over their mothering. Blame and responsibility was a common feature in these studies. Moreover, in the context of parenting, feminist contributions have emphasised maternal blame both in relation to having a child with ADHD (e.g. Bennett, 2003; Malacrida, 2003; Blum, 2007) or more generally with regards to

having a child that is disabled (e.g. Caplan, 1998; McKeever and Miller, 2004). Thus maternal-blame has been seen as a feature of mothering children with disabilities generally. However, the benefit of focusing on the single condition of ADHD points to specific aspects in relation to such blame and responsibility. For example, ADHD currently exists as a controversial disorder and may be associated with particularly challenging behaviour. While it may well be an 'invisible disability' as highlighted by Blum (2007)[§] in terms of observable physical impairments, the disruptive behavioural characteristics associated with the condition may well mean that such parents and children are visible.

In the studies in the review fathers' experiences clearly differed to mothers' in that they appeared less likely to hold a medical view, but they too may have been unable to escape parental responsibility. Further, amongst the studies in the review there was debate over the relative merits of a diagnosis of ADHD in relieving parental blame with some authors (i.e. Kendall, 1998; Klasen, 2000) arguing that a medical diagnosis enabled a medical explanation over a parental one, while others (i.e. Singh, 2003; 2004; Bull and Whelan, 2006) argued that such a diagnosis had limited value in the long term towards parental blame and management strategies. Harborne et al (2004) were less certain and concluded that:

> It is not clear from the accounts whether these parents still felt to blame and blamed for their son's problems. Although many reported that the diagnosis enabled them to feel exonerated from blame, they also spoke about the impact the blame still had on them, which suggests they were not fully able to remove themselves from the aetiological equation…Whether, in fact, teachers and professionals *do* blame parents for the difficulties these children experience, is a matter for further study.
>
> Harborne et al, 2004, p. 335; emphasis original.

Thus, while the studies highlighted maternal blame as a main finding it is not known to what extent a diagnosis of ADHD is able to relieve such blame beyond initial pre-diagnosis blame. Beyond its occurrence then, parental blame (both maternal and paternal), remain poorly understood in the literature. Clearly while feminist contributions have provided greater understandings of mothering children with disabilities more generally, there is a limited research considering specific conditions such as ADHD. In addition, such feminist contributions, while important, have necessarily implied that the focus in the research remains on maternal

[§] The study by Blum (2007) was discussed here in relation to feminist contributions and disabilities. It was not included in the review, however, due to the heterogeneous sample rather than a focus purely on ADHD.

experiences, to the exclusion of father. There is limited research in the area of fathers and ADHD. In essence, it is argued that such feminist analysis may tend to reify the significance of the maternal to the exclusion of the fathers and that further research should be inclusive of fathers. Finally, while parental blame and responsibility was a feature common in previous studies about children with a range of difficulties, there may be specific aspects related to the condition of ADHD which warrant further exploration. For example, in relation to its disruptive characteristics and controversial status as mentioned above, or in relation to the use of treatment medications to control it. The benefit of focusing of the single condition of ADHD in this review, was to indicate specific aspects related to parental experiences with ADHD as highlighted by the themes of: holding different views, parental health issues, battles with others, dilemmas and decisions about medication.

Poor parental psychological health in the literature on ADHD has been widely reported previously and is thus not taken as surprising here. However in Harborne et al's (2004) study, the parents linked their emotional difficulties to the struggles they had faced in gaining help and recognition for their child, and not attributed to the child. In light of the widespread reporting of psychological health problems it is not surprising that some studies recommended further support for parents such as counselling (e.g. Segal, 2001; Harborne et al, 2004; Neophytou and Webber, 2005). The causal mechanisms involved in the relation between the child with ADHD and the family are unclear (as reviewed in chapter 2 in relation to whether the child causes the family disruption or is responding to the family disruption). However, the widespread reporting from the studies here relating to a range of health issues including stress, anxiety, depression, marital problems, physical health issues etc. clearly indicate this population as a vulnerable one in the literature. Clearly parental health problems (regardless of the origin) will have an impact on the ability of the parent to care and manage the child in the home.

Parental dilemmas over medication were also clear from the synthesis. The finding that parents did not like medication and preferred behavioural treatments, was reported elsewhere (e.g. MTA Study, 1999; Bussing et al, 2002). Lay dislike of medication more generally is important because it is the main reason for lack of adherence to treatment regimes as reported by the qualitative synthesis by Pound et al (2005). This was summarised as 'resistance' and is an important area in ADHD for further study in terms of how parental 'resistance' to ADHD medication may occur (e.g. in some of the studies parents sought alternative treatments in order to

avoid the medication). Such issues to do with parental experiences of medication have generally been neglected in the literature. They are important in order to understand parental adherence towards current treatment options in ADHD. Considering the controversy surrounding medications for ADHD and the unique situation in which parents have to make decisions and administer such medications to their children, this is an area requiring further study.

In sum then, findings from the review highlighted that parents held different views about their child's difficulties – most notably mothers. While parental blame and responsibility was a theme here, in common with other areas where children were perceived as different, these experiences here may involve unique aspects to do with responsibility for a controversial condition, parental health issues and battles faced with others as well as decisions about controversial treatment medications.

Critique of the existing literature

Clearly the above studies are an attempt to redress an imbalance in the literature in ADHD where drug trials and clinical aetiology have been privileged at the expense of work examining the qualitative experiences for those that are confronted with ADHD on a daily basis. The qualitative focus on parental (and other) experiences is thus to be welcomed as an attempt to address this gap in the literature. There are, however, a number of methodological and epistemological assumptions underlying this work which will now be elucidated.

Methodological Critique

In addition to the qualitative focus, there are a number of methodological limits intrinsic to the work in the review which will be outlined.

A Focus on the Maternal

There is a tendency within such research to bias the mother in the qualitative studies reviewed. Most of the studies in the review privileged the experiences of the mother with only a few including the experiences of the father. In the studies reviewed: Klasen (2000) included ten fathers in their study. As Singh (2003) noted, studies purporting to investigate the views and experiences of 'parents' often

consisted solely of 'mothers' perspectives and that there was a lack of work which included fathers. Her own work was an attempt to address this. In the studies by Harborne et al (2004) and Hansen and Hansen (2006), the authors included only one father amongst the nine mothers. Bull and Whelan (2006) included only mothers in their sample, as did Bussing and Gary (2001) who used mothers or female carers, but reported on 'parents' experiences. Singh's (2003; 2004) comprehensive work used both fathers and mothers. Taylor et al (2006) included five fathers with their twenty-eight mothers. Kendall (1998) used a sample of fifteen mothers and ten fathers (as well as children and siblings which was reported elsewhere). Other studies focused exclusively on maternal experiences (e.g. Segal, 2001). Neophytou and Webber (2005) reported other family members' experiences elsewhere. Clearly mothers have traditionally been regarded as providing greater responsibility and involvement in the care of their children than fathers in contemporary notions of childcare, but these studies have made claims about parenting a child with ADHD which is a weakness. Previous research has indicated that even in two parent families, mothers have tended to have greater responsibility for the child. For example as seen in Singh's (2003) finding that fathers tended to have different perspectives to mothers about their child's ADHD but that they tended to remain largely silent on this issue. Bull and Whelan (2006) likewise found that mothers tended to consider the father's role as largely ineffective when it came to child management and considered their own role to take on primary responsibility for the child. However, as no fathers were included in the study it was not possible to gauge if the fathers would have supported this view. While there is some justification for a mother-centred approach because of the typically central role that mothers have played in childcare, however, ultimately it is argued that the exclusion of the father in the research appears limited and reductionist. It is acknowledged that research access to fathers may be more difficult than for mothers if they work outside the home but this is a weakness in the research. In line with the above, there is an absence of other significant experiences for ADHD by those that confront it regularly. While parents, particularly mothers, may have greatest day-to-day contact with a child with ADHD, there are other groups that may be considered. There is a lack of studies considering the experiences of the child with ADHD[**]. The classroom teacher is also significant because of the regularity which they may encounter such

[**] However, see Kendall (1999; 2003) for exceptions in relation to the child and sibling accounts of ADHD.

diagnoses in the UK classroom and also for the role which educators play in the actual diagnosis of ADHD, where assessments rest on reported impairments in the school setting.

A North American Bias

Five of the above studies originated from a North American context. There is clearly a North American bias here which reflects the more general dominance of research conducted in a North American context for ADHD. Only two studies originated from the UK, and three studies from Australia. It is clearly important to consider experiences of parents in different cultural contexts other than North America.

The focus on Diagnosis

In addition, work in the review was focused mostly on parental experiences with diagnoses with only a limited number examining experiences with treatment (medication), three studies focused on this area directly while Singh's (2004) work looked at both diagnosis and treatment. As this is highly controversial area it is justified to examine this area in more detail. This is significant when we consider that parents may not be satisfied with the primary treatments for ADHD – medication (as was revealed in the MTA study, 1999). It is therefore surprising that this area has not received more attention as it is an area which may bring parents in conflict with practice guidelines and in terms of non-adherence (e.g. Bussing and Gary, 2001). However, it is recognised that it may not be possible or necessary to separate diagnostic and treatment experiences because parental experiences may be more holistic and integrated, involving both aspects.

Issues of 'Quality' in the review

In considering issues of methodology it is necessary to turn to the overall quality of the included studies. Within health psychology, for example, Yardley (2000) offered flexible suggestions for assessing quality or validity in qualitative research. While the notion of quality in qualitative research is a highly controversial area, it is generally acknowledged to be an important one in order to assess the value of a piece of work. Other types of criteria involve the Critical Appraisal Skills Programme

Collaboration or CASP criteria (2006) in the UK, for example. However, they remain controversial as there are difficulties over the use of checklists as well as assessing studies with different methodologies. Excluding studies in reviews on the basis of the CASP criterion is also highly controversial. In this review then, Yardley's (2000) criteria were considered in relation to the included studies due to their flexible rather than prescriptive nature and because they allow an interpretive and contextual consideration of the individual studies. Further an assessment of quality was deemed appropriate here because (as discussed in the next section) the studies were considered to espouse similar epistemological assumptions, making consideration easier. Such a framework for notions of quality includes: sensitivity to the theoretical and empirical context; commitment and rigour of the work; transparency and coherence and finally the impact and importance of the work.

With regards to some of the relevant criteria, it was found generally that all studies displayed a level of empirical contextual sensitivity, as all studies used empirical data from a specific context in order to focus on parental experiences for ADHD. In light of the suggestion towards commitment and rigour however, it was noted that Segal's (2001) study used data from 1992-1993 which may have been outdated for current ADHD experiences as it is more than ten years old. In addition, Segal's (2001) and Bussing and Gary's (2001) work was not explicit in the type of methodology that was used which affected the study's transparency. Also, the case studies used by Neophytou and Webber (2005) used thematic analysis to arrive at its findings for mothers. While case study research is a reasonable research endeavour and typically relies on a small sample, it is questionable whether such case study research for the mothers' should have been decontextualised to consider the three mothers' experiences without recourse to the wider research and whether thematic analysis of three mothers' experiences is sufficient to arrive at an in-depth analysis.

The studies by Singh (2003; 2004), Klasen (2000) and Kendall (1998) could be considered extensive and rigorous because of their diverse samples (i.e. parents came from a range of clinical and non-clinical areas as can be seen from TABLE 1). The authors were reflexive on the need for a theoretical sample and thus attempted to include parents from a range of areas. This is in keeping with their methodological stances of grounded theory and grounded hermeneutics which depend on theoretical saturation and adequate sampling. By the same token, the non-reflexive stance adopted by the studies by Bull and Whelan (2006) and Segal (2001) should

be considered. Here the critique is not that the authors obtained a sample from only one source, although that too may be a weakness in Segal's (2001) grounded theory analysis, but that they did not consider the sample origin on the findings. The most obvious here is Segal's (2001) sample from CHADD support groups. As was highlighted in chapter 2, parents support groups have been accused of being political advocates for the medical construction of ADHD, and CHADD as a support group has been singled out in particular in this regard. Segal's (2001) study however did not consider the role of including parents from this highly political group on the findings. Klasen's (2000) work, by contrast, considered the origin of the sample in relation to the findings and concluded that regardless of the sample origin (i.e. a medical or a holistic support group), parents tended to support a medical view of ADHD. His reflexive consideration contributed to the credibility of the findings whilst this was undermined in Segal's (2001) work. Finally, Bussing and Gary (2001)'s work used a sample to reflect the ethnic composition of that context (i.e. Caucasians and African Americans) and is thus contextually sensitive.

In relation to the framework for quality, another key aspect of significance here and which related further to reflexivity is the uncritical stance taken towards the construct of ADHD in some of the studies. ADHD as noted in chapter 2 is characterised by controversy, especially in the UK (but also the USA). This uncritical stance towards the concept of ADHD was evident in Klasen (2000), Segal (2001), Bussing and Gary (2001) and may reflect the underlying medical orientation and stance (the work appeared in psychiatric journals for example). Segal (2001) considered parents' alternative explanations for ADHD as 'denial' over ADHD rather than as an alternative but equally valid interpretation. Hence the lack of critical attention to the concept of ADHD itself is noteworthy here and is a reflection of the lack of attempts at reflexivity. Bull and Whelan (2006) were critical of the use of an ADHD diagnosis in their work when they reflected on the limitations that a diagnosis may offer for parents for management. They also espoused social, cultural and historical aspects to account for ADHD which were neglected. Singh's (2003; 2004; 2005) research is distinctive too because it was extensive in its critique by drawing attention to the cultural values and social norms which contributed to the concept of ADHD. In the studies by Hansen and Hansen (2006), Taylor et al (2006) and Harborne et al (2004) however, the concept of ADHD was not particularly addressed. Clearly the authors' own theoretical background and views on ADHD play a role in their research and should be acknowledged as such within a

qualitative paradigm where notions of reflexivity are considered important in maintaining transparency and which were consistent with the methodological approaches adopted by these studies (Yardley, 2000). Further, such theoretical background and views will play a role in the author's own consideration of the impact and importance of the research (i.e. as seen in Klasen's, (2000) research in psychiatry where he argued for an increasing recognition of ADHD by GPs). Finally, it is recognised that the limited critical consideration to the concept of ADHD may be a result of the underlying epistemological stance of humanism and its emphasis on individual subjective experience. This is considered further below.

Epistemological Critique

A Humanist Epistemology

As highlighted above, although the studies employed different methodologies to study parental experiences of their child's ADHD, there was a common epistemological position uniting these studies. While grounded theory is clearly different to interpretive phenomenological analysis, for example, there is an underlying common concern with the phenomenological. Grounded theory originated from sociology and was originally formulated to generate theory about basic social processes (Glaser and Strauss, 1967). Interpretive phenomenological analysis (e.g. Smith, Flowers and Osborn, 1997), on the other hand, originated from a phenomenological philosophy which was focused on investigating the lived-experiences of participants and is thus more psychologically oriented. However, a common humanist and interpretive epistemology underlying these approaches shares a concern with theorising subjective experiences on the basis of such methods as qualitative interviews, despite using different methodologies (e.g. Marks and Yardley, 2004; Yardley 1997). Thus there are common limits of epistemology which could be said to underlie these approaches which will now be considered.

The Focus on the Individual and the uncritical stance to Language

The main limitation with studies employing a humanist epistemology are to do with an emphasis on the individual and an essentially realist perspective taken towards language and its relationship to subjective experience. The focus on individual

experience, it is argued is a necessary attempt to consider such lived-experiences. In the ADHD field this area is neglected. However, it is argued that what this entails is the maintaining of a form of Cartesian dualism where the emphasis is on individual experiences at the expense of social processes and the wider context. Neglect of social processes included such aspects as language. This critique was espoused by Willig (2001) generally who highlighted that such approaches underlying a humanist epistemology, generally tended to rely on qualitative research interviews in order to theorise or interpret findings about subjective experiences or the phenomenological. However, it is generally assumed that participants' language about their subjective experience can reveal or demonstrate some 'truth' about such subjective experiences. This may be more apparent in grounded theory for example, where a post-positivist stance may be adopted towards the data that is generated as grounded and as revealing such underlying structures. It is less apparent in the phenomenological approaches which adopt a more interpretative position. However, Willig (2001) makes the point that even in such interpretative approaches as interpretative phenomenological analysis, there is a tendency to reify the findings of the analysis as if they referred to some underlying structures or truth of experiences. This is evidenced when, for example Smith et al (1997), maintained the assumption of an underlying cognitive structure within the individual by which the researcher gains access to by valid and reliable qualitative methods. The realist assumption towards language and its relationship to experience then, is that it is a neutral and transparent medium for gaining access to subjective experiences and which the researcher makes use. Considering the various specific aims of the studies as shown in TABLE 1, then this is apparent as: parental "aetiological models" (Harborne et al, 2004), "common schemata" (Bull and Whelan, 2006), "decision-making processes" (Taylor et al, 2006) or "explanatory models" (Klasen, 2000). The assumption is clearly that there exist some underlying cognitive structures integral to parental experiences, which can be studied by the qualitative investigator. Hence while such approaches depend on language in interviews in order to generate theory or make interpretations, it is clear that there is a lack of critical attention towards language and its potential in constituting experiences.

An Alternative Tradition

Against a realist perspective towards language and subjective experience, it is useful to draw from Silverman's (2000) distinction between the qualitative research interview as: the 'interview-as-technique' versus the 'interview-as-local-accomplishment'. Within qualitative research, the 'interview-as-technique' is associated with work in the review which employed the research interview as a technique for gaining access to participants' experiences. This was clearly a realist perspective towards language as noted above. However, an alternative perspective may be to treat the research 'interview-as-local-accomplishment'. Associated with this approach is a different perspective taken towards language and which is concerned with the research interview as an example of local and occasioned talk. This approach is focused on studying talk and language as a topic in its own right rather than as a resource to some underlying reality. The focus on language and discourse is central to discursive approaches which emphasise the significance of language as constructive.

Discursive approaches then, which may focus on the research 'interview-as accomplishment', draw from alternative traditions to those from the humanist approach. There has been a wide array of influences in discourse theory. For example, ethnomethodology has emphasised the significance of lay talk as representative of the cultural world and its assumptions (Garfinkel, 1967). The ethnomethodological principle of studying lay member's own methods of sense-making has been influential in these approaches. Harvey Sack's emphasis on the organisation of ordinary, mundane talk was also influential (e.g. Sacks, 1992) with the use of conversation analysis as a distinct field. Austin's (1962) Speech Act theory which emphasised the performance quality of talk and Wittgenstein's (1953) notion of language games was significant for the attention to the function and active properties of language. From semiology the relationship between the sign and the signifier (de Saussure, 1974) was also important as well as influential post-structural theorists such as Foucault, with the inter-relationship between power and knowledge in discourse, as well as the contingency with which historical and social influences have resulted in particular 'knowledge regimes'.

In relation to the above traditions, the benefit of such an approach is illustrated through a classic example from the sociology of scientific knowledge. The authors treated talk (and other forms of discourse) as a local accomplishment rather than as a research technique for establishing the truth or underlying reality of such talk. Gilbert and Mulkay's (1984) study focused on scientists' (biochemists) accounts

of their work. Using an analysis of discourse, they focused on how scientists managed to construct accounts of their own theories as valid while simultaneously accounting for competing and contradictory theories held by other scientists. The authors were not concerned with establishing issues of factuality and scientific validity (i.e. which scientist held the most compelling theory) but were instead concerned with examining the variability and contradictory aspects of the scientist's accounts. This was an influential study which permeated other disciplines such as social psychology where Potter and Wetherell (1987) extended these insights. Their influential contribution to the discipline was to highlight the action orientation of language as well as its constructive role and variability, as opposed to the prevailing traditional view in social psychology and research which presupposed pre-existing attitudes. This approach formed part of a larger 'turn to language' in which the significance and contribution of language was emphasised and represented the crisis in social psychology. Such influences from social psychology were also influential in other areas of psychology such as in critical psychology and critical health psychology. Within health and illness, for example, Radley and Billig (1996) have argued that talk about health and illness should be considered as accounts which are actively constituted and thus should be studied in their own right. This is opposed to the view that such talk should be studied as a means of revealing underlying views or structures. Underlying such departure is the assumption that rather than being the property of the individual speaker and reflecting inner cognitive structures, that language is primarily social. In addition, Billig (1991) has also emphasised the argumentative and ideological role of accounts and how talk is organised to reflect a particular stance and counter-stance.

Discursive approaches

These approaches within sociology and critical health and social psychology have emphasised that talk arises out of a particular social context from which the individual speaker is inseparable. Notions of individual experience, which characterised the humanist epistemology, without recourse to the social make no sense because:

> …all speakers are embedded in social contexts, making use of social resources to constitute their experiences, whether these are experiences of health, illness or professional practice. This involves transforming the conceptualization of the speaker from an individual who is communicating or representing a more or less accurate portrayal of themselves, to a culturally embedded subject actively using shared social resources to perform various and diverse functions.
>
> (Morgan, 1999, p. 69).

There is clearly a need to consider how such social resources constitute experiences about ADHD. Cartesian dualist notions of the individual as an entity that is separate from the social, which have permeated traditional psychology, are clearly rejected in such conceptions. Instead, using approaches such as discourse analysis there is a focus on the social processes that are available in constituting experience by focusing on language. Epistemological assumptions inherent in the humanist epistemology are clearly in contrast to this, with dualist notions maintained of an individual subject versus society. Finally, approaches which focus on language in this way are important because it is recognised that individual experience is constituted and bound within existing social practices. Discourse and language achieves a greater significance because of its interconnection with social action and with the material world (e.g. Burr, 2003; Yardley, 1997). It is therefore important to pay critical attention to such processes if we are to challenge aspects of the material world. So, important research questions are thus able to be posed about ADHD as a discursive topic in its own right and the language that constitutes such experiences.

Thus in sum, the humanist epistemology underlying work in the review could be said to reinforce central assumptions underlying research in ADHD relating to Cartesian dualism. The idea that the individual is separate from the social and can be objectively classified (underlying the biomedical approaches in chapter 2) or that individual experience can be studied in isolation from the social world or social processes that make up the world such as language (underlying the humanist approach in the review) is similarly rooted in such dualism. Thus the humanist epistemology could be said to hold onto a central tenet of dualist notions of the separation of the individual from the social which underpin the medical approach in the first place. Clearly an approach is called for which recognises the inter-relatedness of the individual and social and which transcends such dualism. Such radically different epistemology in psychology theorises subjective experience according to social processes and is considered in the next chapter.

Conclusion

The main strength underpinning research from a Humanist epistemology was also its weakness. While offering a redress in the literature and providing valuable understandings of common parental experiences of their child's ADHD, this research was limited. Methodological limitations with the work included a focus on maternal experiences, a North American context, and a focus on experiences with diagnosis. Research amongst other groups such as fathers and teachers was largely absent. Critical approaches to ADHD as a construct were also necessarily limited. The humanist epistemology entailed the focus on studying subjective experience and which took essentially a realist stance towards language. It was argued that the social processes which are involved in constituting such experiences about ADHD (i.e. such as language in interviews for example) were not given sufficient attention within these approaches. While a phenomenological perspective is valuable in ADHD because it provides greater understandings of how lay people, such as parents, experience medical terms and ambiguities which are valuable to inform medical policy and practice. However, language about ADHD was a neglected area. A discursive approach, by contrast, emphasises the significance of language as a topic in its own right and maintains that talk about ADHD is important because it will have practical and material implications for how we can act. Language about ADHD, moreover, is significant because, in view of current debates surrounding diagnosis in the literature, such focus sheds greater understandings about how those debates are taken up and experienced in practice by lay people. It was argued that the humanist epistemology maintained traditional Cartesian dualism in the manner of isolating such individual experiences from the social processes which constitute them. The discursive approach then can be seen as an attempt to suspend traditional dualist separation of the individual and the social. However, clearly the studies in the above review can hardly be critiqued for failing to focus on aspects that were clearly not within their scope or remit. The following chapter focuses on approaches which have taken a socially constructed and largely critical perspective towards ADHD and focused on the constructive role of language in ADHD.

Chapter 4: Critical approaches to ADHD

Introduction

This chapter focuses on approaches to ADHD which take a critical perspective towards the construct of ADHD and which pay attention to social processes in constituting language and experience. This is in direct contrast to the predominantly positivist, scientific paradigm as seen in chapter 2 and the humanist emphasis on individual subjective experience as seen in chapter 3. Essential to this approach is a socially constructed epistemology towards ADHD as a contingent and contemporary medical explanation for social deviance, as seen in various sociological contributions. The focus on social processes also necessitates a methodological shift towards language and discourse about ADHD. The limited discursive studies in the area of ADHD are examined in order to highlight their contributions. From ethnomethodology and conversation analysis, everyday talk about ADHD is important because it demonstrates actual instances of how members make sense of and construct childhood difficulties. How such talk is able to be utilised and mobilised within a given culture, is also an important feature of study about ADHD in order to understand what a diagnosis may enable and constrain. It is clear that further exploration of this area is required, in view of such limitations in the area of ADHD. With increasing moves to extend the definitions of children's difficulties as ADHD (i.e. the recent upgrade of the European guidelines for ADHD and hyperkinetic disorder, 2004), it is particularly apt to investigate how talk about children's difficulties as ADHD both constitutes and restricts experience for those confronted with it regularly such as teachers and parents.

Critical approaches in ADHD

There is considerable critique of the 'ADHD' construct, yet this critique often remains on the fringes of the dominant biomedical and biopsychosocial constructions of 'ADHD'; absent from contemporary debate in biomedical literature and journals for example. Critical work in ADHD can best be conceptualised on a continuum: ranging from a radical challenge to the construction of ADHD as a valid entity at all, to recognising the condition of ADHD but differing in the solutions and treatments offered. The approaches elucidated here in this chapter, however, will be those that to varying degrees, contribute to a critical consideration of the (medical) taken-for-

granted construction of children's difficulties as 'ADHD' in order to challenge current conceptualisations as problematic. Hence those approaches taking the construct of 'ADHD' as problematic as their starting point will be outlined here. By contrast, other critique appearing in the ADHD literature, which recognise the construct but differ on the proposed solutions, is able to exist alongside the literature and was reviewed in chapter 2. Moreover, while there is an extensive coverage of ADHD in the media, which offers both critique and support for ADHD as a condition, this area will not be reviewed. Finally, in view of seemingly growing medical acceptance of ADHD, it is argued that there is a need for critical debate on this topic in order to reflect on current policy and practice.

Epistemological assumptions underlying critical work

There are a number of underlying assumptions in critical work in ADHD which to varying degrees reflect epistemological assumptions common to social constructionist ideas. Social constructionism refers to a number of philosophical positions which broadly posit the idea that reality or knowledge about ADHD is socially produced in language and social practices rather than being due to any objective and scientific 'facts'. Following Gergen's (1985) original outline of social constructionist ideas in psychology and Burr's (2003) summary, it is possible to offer a framework for such work in ADHD in social constructionist terms: a critical stance taken towards 'ADHD' and notions of individual pathology; a focus and recognition on the historical and cultural emergence of 'ADHD'; the social production of 'ADHD' in medical and clinical practices; and the role of language about ADHD as social practices which (re)produce and contest knowledge about ADHD. While these assumptions may be common to approaches in critical psychology more generally, they appear in stark and radical contrast to traditional psychology. Traditional psychology with its individuo-centred approach is rooted in the empirical tradition in which knowledge is discovered through scientific and objective investigation. Social constructionist ideas within psychology, by contrast, take an anti-essentialist, anti-realist stance towards knowledge and suspend the emphasis on individual cognitive approaches in favour of one that takes the constitutive role of language as its focus (Burr, 2003). While conceived as radical in psychology, such assumptions appeared more prominently in other disciplines such as sociology (e.g. Berger and Luckmann, 1967; Nettleton, 1995). These assumptions for critical work in ADHD will be

explored in greater detail below; followed by the methodological shift entailed with the emphasis on social processes and the discursive in ADHD studies.

A Critical stance towards 'ADHD' and individual pathology

Critical approaches to ADHD share a concern with adopting a critical stance towards the medical construct of 'ADHD'. They differ from work from a biomedical or biopsychosocial construction in questioning this diagnostic category as problematic. While there has been considerable controversy in the literature over the lack of biological markers for ADHD, some researchers have pointed to growing acceptance of DSM-IV criteria and ADHD diagnoses in the UK (e.g. Cooper, 2002). A critical approach is therefore justified in order to reconsider current practice and policy for ADHD and to prevent forestall of this debate. In adopting a critical stance to ADHD, such work tends to challenge the notion of the individual deficit model of pathology which underlies medical approaches. Instead a contextual approach surrounding the way in which such models arise, is endorsed. This will be considered further in relation to individual pathology models implied within ADHD, child developmental models and critical approaches in North America where ADHD originated, as well in other contexts.

Deconstruction of individual pathology models in child psychiatry

Critical approaches to individual pathology are not new, nor exclusive to the ADHD field. The influence of Thomas Ssasz (1974) and other work in the 'anti-psychiatry' movement developed in an American context and was influential in challenging and refuting the acceptance of psychiatric diagnostic categories. Although Ssasz's initial critique in the 1970s focused on schizophrenia as a 'myth', such critique permeated other areas and contexts. Michel Foucault's (1971) influential *Madness and Civlization,* for example, appeared in a European context to trace the historical origins of insanity from the everyday 'fool' in the middle ages to the development of asylums for the insane. Drawing on such work in a UK context, for example, the deconstruction or exposing of underlying assumptions and premises based on psychiatric models has occurred in a range of areas such as: psychopathology generally (Parker et al, 1995) or specific areas such as paranoia (Harper, 1996) and

anorexia nervosa (Hepworth, 1999). Deconstruction of such psychiatric diagnoses has emphasised the socially constructed nature of these diagnostic categories as subjective and contemporary cultural constructs rather than objectively derived diagnoses. Arguments that have been derived from such work have been influential in critical work and extended to the area of child psychiatry and ADHD.

Deconstruction of developmental psychology and the 'normal'

In addition to deconstruction work within psychiatry, insights from a deconstruction of child or developmental psychology are useful for ADHD and the construction of the 'normal' versus 'problem' child. Rose's (1989) classic work highlighted the role of the discipline of psychology in shaping 'norm's of childhood development and emphasised the extensive 'gaze' on children. Erica Burman's (1994) deconstruction of developmental psychology is also important from a social constructionist and critical perspective. This work problematised the applicability of a number of taken for granted assumptions in largely North American developmental models and child psychology. Such assumptions included the largely individualist focus on the child at the expense of the child within the family or broader social network (i.e. culture, society etc). Further, the emphasis in infancy research was on the mother-child dyad at the expense of any other type of social interaction (i.e. father-child; grandparent-child; carer-child) because there was the direct assumption that the mother was the sole or primary carer. Within such infancy research, the mother-child interaction was given great significance and it could be said that the mother's role became viewed as crucial in establishing normal child development. With the traditional maturational model of child development, development was largely seen as a linear process of successful accomplishment of appropriate milestones. However, as Burman (1994) noted, successful development also implied the corollary position, that of failure. The mother of a developmentally delayed child was therefore implicated, through emphasis of the mother-child dyad, within such developmental models as a failure.

This is clear in relation to various influential developmental theorists. Freudian theorists stressed the importance of early childhood experiences for later development and resulting neuroses. Piaget's progressive cognitive developmental stages emphasised the importance of successful development through these stages and served to provide an influential normative basis for such child development (e.g. Boyd and Bee, 2006). In the UK, Bowlby's (1988) influential attachment theory

specified that a secure attachment style with the infant was responsible for adaptive and healthy later functioning. By contrast, an avoidant or ambivalent style of attachment with the infant was less desirable because it resulted in later behavioural problems. Within this theory then, the mother was largely held responsible for the provision of such secure attachment styles in order to foster later adaptive functioning. Likewise, undesirable attachment styles on the part of the mother could be held responsible for a child that displayed deviance from the expected norms. Attachment theory models of ADHD underlying multimodal approaches to ADHD were outlined in chapter 2 in relation to targeting early parenting influences. Modern child developmental theories tend to be more accepting of environmental influences within child development (i.e. often seen as 'risk' or 'protective' factors). In addition, they may recognise the complexity of development as continual development across the lifespan rather than through discrete stages, as well as individual differences in development (e.g. Boyd and Bee, 2006; Rutter and Rutter, 1993). However, it is argued that they are still largely individuo-centred and limited in their consideration of the cultural context in which such theories develop (i.e. largely in North America) and the historical and social aspects involved in which contemporary notions of child development are situated. For example, a number of authors have cited American cultural values which prize 'success' over perceived 'failure' as important in constructing what is 'normal' in child development. This is expanded further below.

Feminist contributions

Feminist contributors have also been influential in critical approaches to ADHD and parenting. Such approaches have drawn attention to essentially mother-blaming practices underlying contemporary child development theories and childcare practices. This is relevant particularly when a child is perceived as different or disabled and where the mother is implicated as responsible for the child's later behaviour and 'outcome' (e.g. Caplan, 1998). Such mother-blaming tendencies underpinning Western cultural norms are considered pervasive and extend to the so called helping professions. Feminist critique of mothering children with disabilities has highlighted how such blame is intrinsic for a range of health conditions as highlighted in chapter 3. In addition, feminist critique has been extensive and argued against the medical intrusion into the lives and domains of women (e.g. in such areas as childcare and pregnancy) and which has rendered women powerless and

disengaged from previously female oriented areas. By emphasising the importance and reliance on the expert midwife and health visitor, for example in pregnancy and infant care, this may actually undermine the mother's own sense of competence and 'expertise'. This has included, in addition to a range of medical experts, a significant rise and popularity in self-help literature on parenting through information technology (e.g. Boyd and Bee, 2006).

Schools and Educational practices

Contemporary mass schooling of children is a recent historical phenomenon and has been signalled as a significant influence in the construction of childhood. With such mass schooling, came the rise of disciplines such as educational psychology which were focused on the study of 'norms' of childhood development and deviations from those norms through intelligence testing and other means. Critics have highlighted that through increased scrutiny of such practices, increasing identification of deviance was possible. Further, Walkerdine (1984; 1993) argued, for example, in contrast to traditional child development theories that child development occurs through a series of normative and regulative practices performed by the teacher and parent which in turn shaped such development. She demonstrated how schooling practices from classroom layout to curriculum constituted and normalised particular models of child development as tied to child-centred pedagogy. The emphasis was clearly on the achievement of tasks as they related to success at school and home. The relationship between boys and educational practices has been particularly examined, in view of the high numbers of ADHD diagnoses amongst boys. This has been highlighted as part of a more general phenomenon whereby boys have replaced girls as the contemporary 'problem population'. This has been tied to boys' relative underachievement at school in comparison to girls, their greater likelihood of being excluded from school, or to receive a statement of need, or to be diagnosed with a psychiatric condition (Tyler, 1997; Timimi, 2005). Critics have argued that the current feminisation of the education system has involved an emphasis on verbal and reading skills, as opposed to practical and active skills favouring boys, and have further highlighted the absence of male role models at school or home (e.g. Timimi, 2005). Although, this argument does rest on gender assumptions about behaviour, it does question specific educational practices. Tied to this, in the UK for example, are current Inclusion practices at

school and pressure on schools to achieve national standards of the curriculum. Clearly boys that tend to display impulsive, hyperactive and disruptive behaviours in the classroom are a particular challenge to achieving such educational goals. Contemporary child-centred pedagogy has also been considered contradictory from an ideological perspective, with the emphasis on the individual child learner and different learning styles, as fostered by an egalitarian ideology and in contrast to authoritarian principles which recognise the expertise of the teacher and subsequent goals that seek to establish discipline (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988). Lloyd's (2006) arguments (see below) are also relevant in relation to the paradox between increasing emphasis on inclusive education and increased use of biomedical/biopsychosocial models for difficulties.

Critical approaches to 'ADHD' in North America

It is only fitting to consider critical approaches to ADHD from a North American context, considering that this was where the original construct of ADHD arose and as recently outlined by Cohen (2006). Contemporary examples of North American critique in reaction to ADHD, and largely influenced by the 'anti-psychiatry' work, included the work of psychiatrist and staunch critic of ADHD, Peter Breggin (e.g. *Talking back to Ritalin*, 1998). Breggin's work extended to the potentially damaging effects of psychostimulant medication on children, based on findings that medication worked equally well for 'normal' children and also from animal studies that showed the detrimental effects of the long-term use of such medication (Breggin, 1998). His critique extended to the political where he highlighted the tendency for research to be co-sponsored by powerful drug companies, including the highly influential Multimodal Treatment Study (Breggin, 2003). His critique also extended to the tendency for vulnerable groups in society to be labelled by psychiatry (e.g. *The War against Children of Color: Psychiatry Targets Inner-city Youth*, Breggin and Breggin, 1998). This is also seen in Walker's (2006) argument that the ADHD label emerged and was applied in a novel manner to the previous 'feebleness of American Indian children' to further disenfranchise this historically and economically disadvantaged group. In Richard DeGrandpre's *Ritalin Nation: Rapid-fire Culture and the Transformation of Human Consciousness*, (2000), contemporary aspects of American culture that were perceived to underlie difficulties with attention and focusing, implicated a 'rapid-fire' culture (i.e. a rapidly moving culture where rapid

information and technology meant that there is a constant bombardment of sensory information). The result of this entailed difficulties with information processing and attention span and changes in human consciousness. This was seen as particularly influential on children with technology such as the television. The paediatrician Lawrence Diller's work *Running on Ritalin: A Physician reflects on Children, Society, and Performance in a Pill* (1998), emphasised the performance-enhancing aspects of Ritalin for school performance and which were tied to American cultural values which expect success and value perfection. This argument was picked up by Singh (2005) who considered the bioethical dilemmas involved in such chemical enhancement of children's school performance and raised hypothetical ethical questions as to whether 'normal' children would in fact be disadvantaged by not being given Ritalin. Further, Cohen (2006) argued that there should be an open acknowledgement over the accepted use of such drugs for enhanced performance at school, rather than the political arguments which served to advocate for the medical status of the disorder. Armstrong's (1997) *The myth of the A.D.D. child: 50 ways to improve your child's behaviour and attention span* is a further example of work which attempted to deconstruct the psychiatric label of ADHD and challenged notions of difficulties with children's behaviour and attention span as being due to a condition called 'ADD'.

The above examples serve to illustrate the type of critique that emerged from within a North American context. However, as Singh (2002) noted, the problem with such critique is that it has tended to remain distant from practice and policy about ADHD. It has often been regarded as extreme 'anti-psychiatry' and sensationalist by fuelling media reports about ADHD and therefore dismissed in the scientific community as 'myths' (e.g. Barkley, 2006). However it's argued that such dismissive attitudes belie the controversy over the current status of the condition. Such critique appears in a broader context where national and international bodies have also been concerned with similar issues. For example the National Institute of Mental Health's Statement (1998) that the concept of ADHD was unsupported in the literature implied that such critique was justified because ADHD was open to debate. Further, the United Nations Narcotics Control Board (2005; 2007) echoed concerns about the rising incidences of psychostimulants for children – most notably in the USA – and was concerned with the effects of direct advertising and marketing of such drugs to consumers. Such concern by these bodies indicates that scientific dismissal of such critique may be premature and unjustified and that attention is

warranted in considering the wider political and economic considerations in the debate about ADHD, in which the medical occurs. Cohen's (2006) call for open acknowledgement of the effects of Ritalin for school performance could be extended to open debate and acknowledgement of the contentiousness of ADHD.

Critical approaches to 'ADHD' in other contexts

Critical approaches in the UK are considered here as an example of the development of critique in other contexts. Contemporary critique may be considered more measured in tone than the earlier 'anti-psychiatry' inspired movements which appeared in the 1970s, as seen above. Two recent examples appearing in this context will be given. The psychiatrist and critic Sami Timimi's (2005) *Naughty boys: anti-social behaviour, ADHD and the role of culture* followed his earlier work *Pathological Child Psychiatry and the Medicalization of Childhood* (2002) in the UK. Similar to work in the 'anti-psychiatry' movement, the earlier work took a critical stance to the field of psychiatry and the labels and processes which it created. In *Naughty boys: anti-social behaviour, ADHD and the role of culture*, as the title implies, the author offered a critical view of rising diagnoses such as ADHD, Asperger's and Autism amongst boys and considered wider social and cultural influences that may contribute to such diagnoses. His focus was largely on aspects of Western culture that may be seen as pathological and contributing to the construction of 'problem behaviour' in children. His work drew anthropological comparisons with other cultures and various sociological insights. Some of the features which he identified as pathological in Western culture included the economic policy of capitalism and consumerism which promoted values that encouraged economic productivity and which thus rendered children dependent and hence less valued. Compulsory schooling practices, as mentioned above, also rendered children dependent as well as increasingly open to scrutiny by various professions such as educational psychologists and teachers.

Timimi's argument about Western cultural values not being conducive to children and their well-being may be supported by considering the recent United Nations report, *Child Poverty in Perspective: An Overview of Child well-being in rich countries* (2007), as highlighted in chapter 1. The report ranked quality of life for children in wealthy industrialised nations according to six dimensions including: material well-being; health and safety; educational well-being; family and peer

relationships, behaviours and risks and subjective well-being. Twenty-one countries were ranked against each other. Overall, despite being two of the wealthiest nations in the world, the UK and the USA were rated at 21st and 20th respectively in terms of their average ranking across the dimensions. Not only did the UK rank lowest in the overall rankings, but it rated lowest for family and peer relationships, behaviours and risks, as well as child ratings for subjective well-being. Educational well-being and material well-being were also lowly ranked for those dimensions, as was subjective ratings of well-being by children and young people. This report highlighted that the UK achieved the lowest child well-being ranking and does raise important questions about child well-being and cultural practices in this context (as well as the USA). It is argued that medical practices common to these cultures, which function to identify children's problem behaviour as 'ADHD' and subsequently control it by medication, may be questioned. It may be justified therefore to critically examine such cultural practices in these contexts. Thus, the general low rankings of child well-being in these contexts, despite their wealth, gives some credence to those critics of ADHD who have argued that greater attention should be paid to broader cultural and economic arrangements which impact on childhood.

While Timimi's work focused on cultural aspects contributing to ADHD in the West, Lloyd, Stead and Cohen (2006)'s *Critical New Perspectives on ADHD* took an educational and critical perspective to ADHD. The work was international in the sense that it sought to highlight critical perspectives from various countries; in addition to a purely North American focus, the contributors ranged from the UK, Australia, South Africa, Italy, Sweden and Turkey. Varied critical takes were offered on ADHD but all espoused the limitations of current conceptualisations for an educational perspective and echoed similar concerns to those mentioned above (e.g. Armstrong, 2006). Some contributors offered empirical work to support such arguments, for example from South Africa, Muthukrishna (2006) considered three children and mothers' experiences for ADHD in relation to Inclusion and Exclusion practices. Little is known about ADHD in Africa, although the Hyperactivity Association in South Africa implicated 10% of children as displaying such characteristics. The work highlighted the complexity of experiences and emphasised critical attention to educational practices which resulted in exclusion. Lloyd (2006) emphasised the paradoxical move towards contemporary moves to inclusive education and the simultaneous increase in 'new medical' and 'biospyschosocial' models. The dominance of the medical profession over deviant children behaviour

was also highlighted over those of educators which was a theme in other contributions. In addition, such epistemological assumptions which focused on the individual and disease models rather than contextual aspects were held to be limited for children and educators.

The similarity of the above critique is over the critical stance taken towards the construct and consideration of wider contextual aspects in the child's environment such as Western cultural values and the educational context. The value of the above arguments are that in contrast to the theories characterising individual pathology models in child psychology and psychiatry which attempted to highlight aspects of the individual child or mother that may be pathogenic and contributing to ADHD, these approaches considered aspects of the wider social, historical and cultural context which may actually be 'pathogenic' in producing the diagnostic category ADHD. Such approaches offer valuable and novel insights and understandings about ADHD. While these arguments are compelling (to varying degrees) because they raise contextual aspects surrounding children's behaviour problems which are not given much scope in the biomedical literature and they can be considered scholarly in their contribution to debate about ADHD, the main limitation with such work is over the relatively limited empirical basis for such arguments. Timimi's work for example largely relies on anecdotal accounts of children's behaviour in different contexts and his own case study experiences with patients. Singh's (2002) contention that critique often appears outside of policy and practice is further reminiscent here. Further, there is a need for scholarly argument and critique to be grounded in empirical research so that such arguments are persuasive.

The relevance of such critique is seen in similar concerns that have been raised by national bodies, to those highlighted above. Within the discipline of psychology, for example, the British Psychological Society's Working Party for ADHD (1996) concluded that more stringent criteria should be adopted in diagnosis such as used for hyperkinetic disorder and that ADHD was an 'evolving' concept. Cooper (2002) argued that there was later growing consensus and acceptance of ADHD because in 2000, the British Psychological Society issued guidelines on ADHD. These guidelines advocated a multi-agency approach towards ADHD. However, in the 2004 special edition of *Clinical Psychology* a critique of ADHD was published as a medical construct. Once again, contributors ranged in the critique from advocating alternative and holistic approaches to attention to ADHD as a

cultural construct. This debate within the discipline of psychology indicates the current ambivalence towards the construct, but equally demonstrates contemporary professional concerns about its status.

A treatment derived construct: The historical and cultural emergence of 'ADHD' in North America

As Singh (2002) noted, the history of ADHD in the biomedical literature is usually characterised by scientific progress and discovery. For example, in Conner's (2000) account the British paediatrician George Still (1902) was credited with the first clinical identification of children with attention difficulties. During a series of lectures he described a group of twenty children that exhibited signs of excessive impulsivity and attention difficulties without signs of brain damage or retardation. This was termed 'an abnormal defect of moral control in children' (1902:1008). This reflected the language of the day and referred to an inability to control behaviour and react according to sound judgment (Conners, 2000). Here 'moral control' referred to: 'the control of action in conformity with the idea of the good of all' (1902:1008). These difficulties were reported to occur more frequently amongst boys. This initial clinical observation proved influential in later work. In 1937, Charles Bradley, a medical director in Rhode Island, USA, noticed that children with neurological damage in his hospital displayed dramatic improvements in their behaviour when given psychostimulant medication (namely the amphetamine drug Benzedrine). The effect was observed as 'paradoxical' as behaviour and school achievement improved. This was later replicated by Stauss and colleagues in 1947 with postencephalitic children who had minimal brain damage; resulting in the term 'Minimal brain damage syndrome'. Laufer and colleagues in 1957 later termed this 'hyperkinetic impulse disorder'. As a result of the range of terminology surrounding the concept at this time, the 1963 international conference in Oxford sought to allay such confusion and settled on the term 'Minimal brain dysfunction' to replace 'Minimal brain damage'. Further, the US Public Health Service and the National Association for Crippled Children and Adults' 1966 taskforce, saw 'Minimal brain dysfunction' (MBD) emerge as the overarching term of choice over hyperkinesis. In 1961 the US Federal Drug Agency approved the psychostimulant drug methylphenidate (i.e. Ritalin). This drug worked in the same way as the amphetamines used earlier but was considered

superior because of less undesirable side-effects. Since then methylphenidates (Ritalin) have been instrumental in treatment approaches to ADHD (as seen in chapter 2) and are often synonymous with ADHD in media reporting. Finally in 1980 the term 'MBD' was superseded by the term 'ADD' or Attention deficit disorder by the American Psychiatric association's DSM-III specification. In this specification difficulties with attention were seen as the overriding feature, which could be present with or without hyperactivity. DSM-III-R, however, united features of inattention with hyperactivity and impulsivity into a single unified condition. This was later modified in DSM-IV (1994) which returned to the earlier specification of division and which indicated three subtypes: an inattentive subtype, a hyperactive-impulsive subtype and a combined subtype.

Conrad (1976/2006) and Conrad and Schneider's (1992) sociological analysis however, appeared in stark and radical contrast to the biomedical progress as highlighted above. Social aspects were highlighted in contrast to the medical paradigm. For example they noted:

> What stands out to a sociologist is that the treatment was available long before the disorder that was being treated was clearly conceptualized. It was 20 years after Bradley's discovery of the "paradoxical effect" of stimulants on certain deviant children that Maurice W. Laufer named the disorder and described its characteristic symptoms (behaviours). In terms of the sociological study of deviance this is most interesting. The social control mechanism (in this case, pharmacological treatment) preceded the label (hyperkinesis) by 20 years. This presents an interesting problem for a sociological perspective: Do medical labels appear when medical social control mechanisms are available?
>
> (1992, p.159)

The analysis offered by the authors, essentially maintained that it was the development of the treatment drugs which affected children's behaviour that led to the labelling of such behaviours as a discrete condition and under medical control. Thus in response to the question (i.e. 'Do medical labels appear when medical social control mechanisms are available?') the authors concluded with a 'tentative yes' (1992:161). Other social aspects that were significant in the development of 'hyperkinesis' in the USA were also considered such as the pharmaceutical revolution; trends in medical practice and government action. Increased advertising and use of psychoactive drugs for children occurred in the 1960s. With the greater use of these drugs within the mental health area in general, together with a growing interest in child mental health and psychiatry, children's behaviour and the potential for medical management became increasingly under the auspices of the medical

professions. Government action in the 1970s was seen to offer templates for the treatment of children's hyperkinesis with medication (e.g. that physicians be responsible for diagnosis and prescribe medication). In addition to the powerful pharmaceutical industries, the Association for Children with Learning Disabilities was also considered influential in promoting a medical conception of children's behaviour in educational contexts. Thus these social and cultural influences were important in the 'discovery' of hyperkinesis. Conrad and Schneider's (1992) outline and Conrad's (1976/2006) original sociological study of hyperactive children remain as key departures from the biomedical perspective and the analysis of historical and social influences in the emergence of the construct.

As noted in chapter 2, the term 'ADHD' (and before it, 'ADD') arose from within a North American context and was defined by the American Psychiatric Association. In Europe, the term 'hyperkinetic disorder' was traditionally used which is a much more narrowly defined condition which referred to severe and enduring hyperactivity. The modern day 'ADHD' term in the UK and Europe can thus be seen as a cultural arrival from the American classification system which has been gradually assimilated into these contexts. Its arrival in these contexts is somewhat recent, and which are clearly being extended to other contexts such as developing countries. In Sweden, for example, the disorder DAMP was used to refer to Dysfunction in Attention, Motor control and Perception. ADHD in these contexts has increasingly been used. For example the European clinical guidelines for hyperkinetic disorder – first upgrade (2004), made use of both hyperkinetic disorder and ADHD, seeing 'no contradictions involved' (2004:1/9). Instead the authors recommended using both concepts. As highlighted in chapter 2, the mass media and use of information technology has contributed to extending the concept of ADHD beyond North America.

Medical and clinical practices of 'ADHD'

Underlying this assumption is the recognition that that ADHD is socially produced and fundamental to contemporary medical and clinical practices which accomplish such diagnoses of children's problem behaviour. These are discussed below.

The Medicalisation of children's behaviour

The sociological contribution to the study of ADHD and the increasing labelling of such behaviour presents a challenge to the medical one. Conrad's classic study of hyperactive children was used to illustrate the broader sociological process of medicalisation. Medicalisation refers to the process whereby a previously non-medical entity comes to be defined and under the auspices of medical terms and control (Conrad, 1976/2006). Parallels with other theorists with regards to such work are clearly evident (i.e Thomas Ssasz and Michel Foucault). For example, Foucault's medical 'gaze' ('Le Regard') is clearly influential in the process of medicalisation. The 'gaze' referred to the medical profession's power and influence. In *The Birth of the Clinic* (1973), Foucault traced the emergence of the Clinic (which referred to the institute of medicine), not as a progress of modern science, but rather as contingently formed.

Conrad's (1976/2006) classic work was an empirical study of hyperactive children, as it was then defined in the USA, from a specialist clinic. The following key insights were generated from the work: the school and family, rather than the physician, was key in the identification of such children; the school had greater influence than the family in achieving medical definitions; the identification of such children usually occurred as a 'turning point' as when management and control became a central issue – rather than any change in the child's behaviour; physicians created a medical definition of the problem in order to justify the medical treatment. At times, the school was also found to put the parents under pressure to refer the child for medical assessment. Although these were noted as humanitarian efforts, they had other implications. It created a problem of expert control of such behaviour, of medical social control, and emphasis on the individualisation of social problems and the depolitization of deviant behaviour. Recently this process of medicalisation of children's behaviour has been extended to adults (Conrad and Potter, 2000/2006). From the original work an initial theory was generated of the process of medicalisation in modern, Western, industrial societies which were characterised with a scientific worldview and powerful medical profession. Central to the process of medicalisation, Conrad noted, were lay 'claims-making' (i.e. by teachers and parents) in conjunction with professional ones. In *Deviance and Medicalization: From badness to sickness* (1992), medicalisation and children was considered in relation to - not only hyperkinetic disorder - but also delinquency and child abuse.

The change in terms from ‘badness’ to ‘sickness’ highlighted how aspects that were previously considered within moral confines came to be reconceptualised as ‘sickness’. This shift in terminology warranted ‘help’ in the form of medical interventions and also entailed that parental responsibility and guilt could be thereby removed to organic causes (Conrad and Schneider, 1992).

Armstrong’s (1995) extension of the Foucauldian ‘gaze’ from the Clinic into the realms of the community is also useful, with the notion of the rise of surveillance medicine. Here the influence of the medical profession was felt in the community whereby ordinary people or ‘lay’ people identified medical problems and used medical terms to explain it. It also referred to the rise of professions that entered the community. From Armstrong’s (1995) surveillance medicine in relation to ADHD, and Conrad’s work, it is clear that the emphasis is on not only the medical profession in order to achieve the aims of medicalisation, but on lay people as well. Parents and teachers in ADHD are intrinsic to such medicalisation because they, in effect, identify difficulties and place the child within the medical scope. In essence then, medicalisation depends on such lay assimilation. In sociology, the process of medicalisation is complex and will be expanded here. Lupton’s (1997) distinction is useful between a Foucauldian medicalisation critique and an orthodox medicalisation critique. While the orthodox medicalisation critique rested on Marxist notions of power imbalances between the powerful medical profession which tended to exert its influence and control over the relatively passive lay patient, a Foucauldian medicalisation critique was less overt. In contrast, a Foucauldian medicalisation critique saw subtle power relations existing in which the professional and lay patient engaged in a dynamic and relational context. Hence power dynamics were always being colluded, (re)produced and resisted in any given context. Lupton (1997) argued against the relatively passive connotations of the patient within some interpretations of Foucault’s work in favour of one which recognised the dynamics of the relationship. The argument was made further for a study of the ‘phenomenology of power relations’ in medicalisation research and which was particularly lacking (1997: 103). This is useful because it draws attention to the unique way in which non-medical groups such as parents and teachers in ADHD for example, are able to (re)produce, contest and construct ADHD in the children around them. The way in which such groups experience medical power relations therefore is an area which is also implicated by the above. Finally, in contexts such as the UK, ADHD has been considered ‘incompletely medicalisation’ or medically uncertain/contested. The

complex arrangement of the process of medicalisation in an incompletely medicalised area was illustrated by Broom and Woodward (1996). The authors showed how the process was both helpful and less helpful for Chronic Fatigue Syndrome. It is expected that there may be parallels with ADHD where the process of the medicalisation of children's behaviour would have complex 'helpful' as well as 'unhelpful' consequences. This was highlighted as an area for further research in Conrad's work.

In sum, the process of medicalisation in the field of ADHD highlights that the process depends on lay collusion and participation in such complex arrangements, not only medical dominance. The complexities of the arrangements for parents and teachers are likely to have a range of implications, particularly in incompletely medicalised conditions such as ADHD in the UK. How such lay parents and teachers, further contribute to and experience such medical arrangements is an area requiring further study.

ADHD in Clinical practice

As noted in chapter 2, a diagnosis of ADHD depends on interpretation and largely subjective factors by the clinician. The clinician can be seen therefore, to be engaged in the process of medicalisation where individual clinicians (re)produce and construct ADHD diagnoses in practice. Critics have highlighted the tendency for diagnoses of ADHD to be socially produced in the medical consultation and the discrepancies between the rhetoric in guidelines on ADHD in comparison to what happens in clinical practice. Conrad's (1976/2006) study highlighted that social processes were involved in the diagnosis of hyperactivity where 'physiological realities' were inferred from 'social realities' (1976/2006:90). This was echoed by others such as Timimi et al (2004) who highlighted that diagnoses are largely a subjective and interpretive matter by the clinician who is called on to interpret behaviour rating scales which have been completed by the parents and teachers and who may observe the child in the clinic. Further that there is generally no observation of the child in everyday settings (i.e. at home and at school) however, and that the child in the clinic may behave somewhat differently in such an environment. While diagnosis is an attempt to identify those children with pervasive clinical symptoms of ADHD in an attempt to satisfy DSM-IV requirements (i.e. that symptoms occur in two or more settings and were present before the age of seven),

it is clear that diagnoses in practice depend on the clinical judgement of the clinician. Critics have highlighted that no objective tests exist for the clinician (i.e. blood test, brain scan) in order to make this diagnosis. Instead various behaviour rating scales with a checklist of symptomatic behaviour are used which have been completed by the teacher and the parent.

Two common checklists that are used will be considered as an example. The Conners' Parent Rating Scale – Revised (L) and the Conners' Teacher Rating Scale – Revised (L) (Conners, 1997). The long version of the Parent scale contains an 80 item list of problem behaviours which are then rated by the parent according to a Likert scale (which ranges from: 0- Not true at all to 3- Very much true). The subjective and interpretive nature of the checklist is seen in items such as: 'hard to control in malls or while grocery shopping' or 'excitable, impulsive' and 'runs about or climbs excessively in situations where it is inappropriate'. The difficulty for the parent and teacher in the last item for example, in judging 'excessive' running or climbing and in judging 'situations where it is inappropriate' from situations in which such behaviour is appropriate will depend on social, cultural and subjective factors. Other ADHD Rating scales include the ADHD Rating Scale-IV: School Version or Home version (DuPaul, Power, Anastopoulos and Reid, 1998). The school version consists of 18 items describing problem behaviour which are then interpreted by the teacher on a Likert scale (ranging from 0: never or rarely through to 3: very often). Examples of such items include: 'fidgets with hands or feet or squirms in seat' or 'fails to give close attention to details or makes careless mistakes in schoolwork' and 'is "on the go" or acts as if "driven by a motor". Critics of such rating scales indicate that there may be many reasons, for example, why a child 'fails to give close attention to details or makes careless mistakes in schoolwork' such as school bullying, traumatic experiences at home etc. The subjective rating of such behaviours as fidgeting and squirming, again, is clearly apparent. In multimodal assessment, the clinician may also rely on school progress reports or the results of psychological assessments in making a diagnosis. The reliance on these behavioural checklists, however, indicates the subjective nature and contingency of such diagnoses. There may also be problems for the consultant when the behaviour rating scales from the two settings contradict each other (i.e. the school may indicate that the child does not display any signs of problematic behaviour while the parents may indicate profound problems at home).

Finally, in relation to the above, discrepancies between parent and teacher reporting about ADHD 'symptoms' on behavioural checklists such as those discussed, is well known in the literature in ADHD. Reasons for such differences have ranged from the child behaving differently in the different contexts, inter-rater differences as well as different levels of tolerance for such behaviours. Medical proponents for ADHD such as Barkley (2006a) have generally made light of such differences between parents and teachers and pointed to the low correlations amongst these groups more generally. However, clearly for the clinician the situation is challenging, because a diagnosis depends on problems being reported in two settings. Some surveys have indicated that school reporting is more 'reliable' than parental reporting and that the motivations of the parents are considered to have an impact on such ratings (e.g. such as obtaining a diagnosis of ADHD and being entitled to disability living allowance in the UK). Clearly this presents complications for the clinician.

Methodological assumptions underlying critical work: Discursive studies in 'ADHD'

Tied to the epistemological position of the focus on social processes in constructing ADHD, there is an emphasis on language and discourse which serves to constitute ADHD. This section focuses on empirical studies in ADHD using a discursive approach. This occurs in relation to institutional and clinical practices as highlighted above and in relation to talk by both lay and professionals. As highlighted in chapter 3, such work which focuses critical attention to language and social processes as significant derives from traditions spanning ethnomethodology and conversation analysis (Garfinkel, 1967; Sacks 1992), Austin's Speech Act theory and Wittgenstein's linguistic philosophy, semiotics (de Saussure, 1974), the sociology of scientific knowledge (Gilbert and Mulkay, 1984), and post-structuralism; for example in psychology (Henriques, Hollway, Urwin, Venn and Walkerdine, 1984; Davies and Harré, 1990/2001). Discourse analysis is an approach in the social sciences which refers to a variety of approaches and derives from a range of influences, but which broadly emphasise the significance and constructive role of language. Potter and Wetherell's (1987) original formulation was influential for approaches in social psychology which emphasised the function or *action orientation* of language in given contexts. There are, however, disparities in contemporary discourse analysis which entail very different emphasis such as on the rhetorical devices underlying the

performance of talk in discursive psychology (e.g. Edwards and Potter, 1992) or on the deconstruction of power relations underlying language and wider discourses (e.g. Parker, 1992). Hence this section will outline the various types of discourse analytic approaches before considering the contribution of empirical studies to ADHD.

Methodological considerations in Discourse Analysis and ADHD

Within psychology, for example, there has been a general trend to distinguish two areas of discourse analysis (DA): discursive psychology and Foucauldian discourse analysis (Willig, 2001) or alternatively as: conversation analysis, discursive psychology, interpretive repertoires and Foucauldian discourse analysis (Burr, 2003). Recently, Wooffitt (2005) in a comprehensive comparison of conversation analysis and discourse analysis, distinguished between 'bottom-up' approaches which tended to be empirically driven approaches to data and 'top-down' approaches which tended to be theoretically informed analyses. These are considered further in relation to the various approaches to DA.

***'Bottom-up' approaches in discourse analysis*:** These approaches tend to be empirically driven and fine-grained approaches to analysing talk. Particularly influential, has been the use of conversation analysis and its focus on everyday talk-in-interaction and on the sequential organisation of this talk. Analysis is typically concerned with such aspects as 'turn-taking' in conversations or 'adjacency pairs' in managing requests, invitations and greetings, for example (Atkinson and Heritage, 1984; Drew, 2003). Conversation analysis yields valuable insights into the normative basis for such features of everyday conversations and thus deviations to such norms can be the basis for analysis. Conversation analysis derived from the ethnomethodological concern with the mundane and ordinary members' own sense making. Hence, the focus in conversation analysis is on empirically demonstrable evidence of the speaker's own orientation within a conversation such as to prior turns for example. Thus analytic claims are grounded by reference to empirically demonstrable features of the talk in interaction without reference to broader theoretical or contextual claims.

Discursive psychology emerged largely as an attempt to reconceptualise the field of social psychology with its traditional focus on cognitivism and empiricism.

Typically discursive psychology applied aspects of conversation analytic techniques to a range of psychological topics such as memory, emotion and attitudes in an attempt to rework these topics as discursive phenomenon that are invoked in everyday talk (e.g. Potter and Wetherell, 1987; Edwards and Potter, 1992). Hence, there is typically a fine-grained focus on the details of talk or rhetorical strategies as influenced by conversation analysis. Early discursive psychology was concerned with such aspects as managing stake in talk or making accounts factual (Edwards and Potter, 1992; Potter, 1996) or disclaiming racist remarks (Potter and Wetherell, 1988). Contemporary discursive psychology is concerned with such areas as emergency calls to a child protection helpline (e.g. Potter and Hepburn, 2003); discursive practices of eating (e.g. Wiggins, Potter and Wildsmith, 2001; Wiggins and Hepburn, 2007) or the discursive construction of specific controversial conditions such as M.E. (Myalgic Encephalomyelitis) (e.g. Horton-Salway, 2001; 2004; Guise, Widdicombe and McKinlay, 2007). The contribution of such approaches has been on highlighting the active discursive devices used in everyday, interactional talk. There is increasingly a turn to greater use of conversation analytic findings and conventions in current discursive psychology and a focus on naturally occurring data (e.g. Potter and Hepburn 2003; Edwards, 2005). Epistemologically, proponents of discursive psychology have typically argued for a relativist position where there is no notion of an objective reality beyond what can be demonstrated by reference to the text (e.g. Edwards, Ashmore and Potter, 1995).

'Top-down' approaches in discourse analysis: These approaches tend to be theoretically driven and include such approaches as Foucauldian discourse analysis and Critical Discourse Analysis. Both approaches tend to be concerned with the wider operations of power and inequalities in society and how these are manifest in talk, texts or 'discourse'. A Foucauldian discourse analysis typically draws on the work of post-structuralists such as Foucault's notion of power/knowledge and the operation of discourses, or Derrida's notion of deconstruction. A Foucauldian discourse analysis would typically consider discourses as powerful, all-encompassing systems and would look to trace and demonstrate how these operations occur in particular texts to (re)produce and reify the dominant and prevailing discourses in society. A discourse has been defined as: 'a system of statements which construct an object' (Parker, 1992:5). Such approaches have typically been critical approaches in psychology and have been concerned with the

workings of power effects (including within the discipline of psychology itself) (e.g. Parker, 1992; Burman and Parker, 1993). Foucauldian discourse analytic approaches have focused on such areas as the discursive positioning of women smokers (e.g. Gillies, 1999); sex education policies (e.g. Willig, 1999) or historical genealogical analyses of unmarried motherhood (e.g. Carabine, 2001). Critical discourse analysis is specifically focused on inequalities in society and how they operate in language and discourse. Forms of Critical discourse analysis draw from linguistics and Marxist notions of power in order to be politically informed and explicit about the starting point for analysis (i.e. from the point of view of the oppressed) (e.g. van Dijk, 1993; Fairclough, 1995; Wodak, 1996). Such analyses may be concerned with areas such as the discourse of new labour (Fairclough, 2001). Proponents of 'top-down' approaches such as Parker (1992) have typically advocated an epistemological position of critical realism where reality (or the social world) is recognised to influence and produce discourse.

Empirical studies in DA and ADHD

In the following section, previous discursive work in the area of ADHD and related areas is discussed according to the main areas which have been addressed. The contribution and the limits of these approaches are also discussed.

Lay focus: Parents, Teachers and ADHD

Following Conrad's (1976/2006) original early study, there have been significant contributions to ADHD from a sociological and a discursive perspective. Malacrida (2001, 2003, 2004) used a Foucauldian discourse analysis and feminist critique in a cross-cultural study with mothers of children with ADHD in Canada and England. Malacrida's (2001) analysis highlighted that mothers represented a vulnerable group in society in relation to the medical and helping professions. Analysis of interviews with mothers in two settings indicated that mothers tended to conform and resist medicalisation of their child's behaviour as 'ADHD' in order to be preserved as 'good mothers'. Strategies that they employed to do this included attempts to normalise the child's behaviour, include a male role model in joint meetings about the child and by highlighting efforts that they were engaged in to deal with the problem. They also

engaged in scrutiny of the helping professions by keeping their own files and documents of the child, and by volunteering to work in the school in order to monitor the child at school. Malacrida (2001, 2003, 2004) claimed that mothers had limited success overall in the face of such professional involvement and were acutely aware that they were being scrutinised and held responsible for their child's behaviour. There are clear parallels here with the cultural motif of the 'good mother' that was found arising from qualitative interviews with mothers in chapter 3 as well as the moral dimensions. This resembled Bennett's (2003) doctoral study which had also focused on mothers' accounts of their child's ADHD, using Foucauldian discourse analysis and discursive psychology in England. This work highlighted how the 'blameworthy' mother was a central and pervasive feature in the study. The work considered how this was related to mothers' efforts at engaging with the medico-scientific discourses that prevailed about their children, as well as other discourses. In addition, Malacrida's (2001) analysis and Bennett's (2003) study paralleled Blum's (2007) findings where mothers were engaged in a range of vigilante efforts with the medical professionals and educators.

Malacrida's (2003) work also had implications for educators. There is little research in the area of teachers and ADHD, however. When conducting a literature search on experiences and views of ADHD (for chapter 3), teachers were largely absent from the literature. Considering their day-to-day contact with children and the Inclusion agenda in UK schools, this appears surprising. Malacrida's (2003; 2004) research is significant here because although the work did not actually research teacher perspectives, it did focus on mothers' perspectives of the role of educators for ADHD in the two settings. Her work showed that in Canada mothers saw teachers as pushing for medication for their child's ADHD because they had few alternative means of social control in the classroom. Hence they were proactive in this context at identifying potential ADHD cases but were unwilling to be involved in any non-medical treatments such as behavioural strategies in the classroom. In England, however, teachers were seen as reluctant for medication to be used to control children's behaviour as well as over diagnoses of ADHD because they appeared to have greater means of social control in the classroom (e.g. through exclusion). Malacrida highlighted the ambivalent position for teachers in England because while they had the greatest contact with children with ADHD they were the least likely to be viewed as collaborating professionals. She cited the Guidelines on methylphenidate (Nice, 2000) which were circulated to a range of professionals but

did not include schools. There is clearly an additional need for research amongst teachers in view of their absence from the literature and because, at least for the mothers in Malacrida's work, this was where the greatest conflict over ADHD occurred. Norris and Lloyd (2000) also highlighted in an analysis of media reporting about ADHD in the UK, which included Scottish papers, that teachers and GPs tended to be neglected in media reporting about ADHD and were less likely to be regarded as experts in favour of paediatricians and psychiatrists. While there is a lack of research with teachers, a cross-cultural survey amongst British and Canadian teachers indicated that teachers in both sites supported a medical model for ADHD. British teachers, however, had experienced greater contact with medical professionals over ADHD than their Canadian counterparts but had received much less information and training on ADHD (Couture, Royer, Dupuis and Potvin, 2003). Cultural aspects relating to teachers' perceptions were highlighted by a study that showed that Greek teachers viewed 'hyperactive' children more favourably than the 'inattentive' and 'combined' groups for ADHD (Kakouros et al, 2004). 'Hyperactivity' or being energetic was seen as a positive trait and this study clearly points to the cultural meanings that are thus given to children's behaviour and thus the importance of cultural aspects in constituting deviance.

In addition to the above, Rafalovich (2004) conducted an empirical study with parents, children, teachers and clinicians in the USA, using a Foucauldian genealogical approach and a grounded theory approach. The work was a valuable contribution of the variety of ways of framing such difficulties. The work was significant because it highlighted how teachers were engaged in 'semi-formal suspicion' of children's difficulties following Conrad's early study. Clinician's tended to view this as professional encroachment by the educators. The work explored how clinician's managed uncertainty for ADHD. Generally there was a lack of unified protocol or guidelines for teachers in relation to ADHD. In addition, while there was a small number of 'disbelievers' amongst the teachers, the school was increasingly involved in identification of difficulties as ADHD and organised in dealing with such difficulties. There was greater specialist knowledge by both parents and teachers in terms of ADHD knowledge. In addition, Malacrida's (2004) findings that schools tended to 'push' for medication in Canada and that parents tended to negotiate with schools and clinicians regarding treatments and sought alternative treatments were echoed in Rafalovich's work. Here too teachers appeared to regard the medication as important for treatment. Malacrida also highlighted how mothers in both contexts

turned to the use of alternative and complementary treatments and this was a further feature amongst Rafalovich's parents. In addition, Rafalovich highlighted how parents tended to educate themselves and how they empowered themselves in doing so. The work outlined the contradictory causes of the child's difficulties as held by the parents, which paralleled the literature.

Danforth and Navarro (2001) examined everyday language events that were recorded by research assistants in journals, by lay people and in the media in a range of non-professional settings in Missouri, USA. The analysis was framed in social constructionist discourse based on Gee and Bakhtin. Two dominant discourses that underpinned such language events highlighted a dominant medical discourse and a school discourse. The medical discourse was so pervasive in everyday language that it was considered that 'people must contend with it in some fashion' (2001:174). Inherent in the school discourse, was the dual emphasis by schools, on behavioural conformity and academic achievement. The authors noted that most language events referred to actual people known to the research assistants which indicated the widespread use of ADHD terms, and also that most occurred with negative connotations rather than positive ones. There were five themes that were highlighted in relation to these events. In *appropriating the DSM-IV descriptors*, the authors noted that while DSM-IV criteria intended that diagnosis and classification of children's difficulties is clearer, when ordinary people made use of such criteria they did so in their own idiosyncratic ways which reflected contradictory elements. The second theme, *schools as identity construction sites*, highlighted the significance of the school as an institution that was fundamental to individual 'success' and identity. Teacher entries ranged from support for medication to being ambiguous about ADHD, and finally, to resisting such labelling. In the third theme, *resistance: biology versus moral culpability*, lay people contested the medical and school explanations as ADHD in favour of language events that centred around the moral responsibility and agency for that behaviour. Here alternative views invoked such aspects as good parenting, motivation, life circumstances and self-discipline as possible explanations for the child's behaviour. In *alternative solutions of a real problem*, lay people accepted the diagnosis but resisted medication as the treatment in favour of other alternatives such as diet, etc. Medication often appeared in negative terms as well as language events about the side-effects. The final theme, *relief and hope through naming,* was related to the positive aspects related to diagnosis for parents and teachers which implied a sense

of relief and hope that a solution could be found. This work highlighted the moral dimensions in lay language about ADHD and raised moral dilemmas for the restrictions by the dominant medical and educational discourses in terms of the definition, solutions and identity related to the problem. Although noting the fluid and creative use of language, it was also a political site and the authors highlighted that:

> We are struck by the way many speakers struggle to wrestle power back to themselves, their children, and their families by subverting or reconceptualizing the significance of these individualistic and competitive themes into a practical language of social equality, communal living and, and personal agency.
>
> (2001,p.186)

Consultations: Lay and Professional Constructions

McHoul and Rapley (2006) demonstrated how routinely and widespread an ADHD diagnosis occurred in everyday medical consultations. They used a mixed discourse analysis from Conversation Analysis and Critical Discourse Analysis and focused on the accomplishment of an ADHD diagnosis in a single case consultation in Western Australia (where diagnoses are higher than other parts of Australia). In contrast to the medical construction of ADHD diagnoses as a process requiring DSM-IV criteria and behaviour checklists, their analysis highlighted how a diagnosis occurred routinely and in the face of active resistance to such a diagnosis by the parents as well as alternative explanations offered for the behaviour. This work demonstrated the importance of medical language in constructing an ADHD diagnosis in the face of alternative lay constructions. Outside of ADHD but within the field of disability research, similar findings were highlighted by an analysis by Mehan (1996/2001). The analysis highlighted how professional discourse by a psychologist achieved dominance over the counter perspectives by the teacher and mother at a committee meeting to discuss the child's difficulties and a possible placement in a programme for the disabled. It highlighted how the child came to be seen as 'learning disabled' following the individuo-centred explanations by the psychologist rather than social and temporal (by the mother and teacher). The work highlighted how the mother and teacher were rendered powerless in such interactions through professional jargon for example. This paralleled McHoul and Rapley's (2006) analysis of the case consultation for ADHD in which the medical and scientific opinion (i.e. the consultant) prevailed over the views of parents, and which resulted in an ADHD

diagnosis. Similarly Malacrida's work, as indicated above, also highlighted that mothers were ultimately limited in their endeavours at resisting medicalisation of their child's behaviour.

Finally, in the area of medication and ADHD, while there is limited research conducted in the ADHD field on qualitative experiences of medication (as highlighted in chapter 3) and possible research that has suggested that parents do not like using medication for their child's ADHD, there is also a need for further research in this area. Lay difficulties in expressing aversion to medications in GP settings were found using a conversation analysis of consultations and research interviews for a range of illnesses (Britten, Stevenson, Gafaranga, Barry and Bradley, 2004). Lay dislike of medication, as highlighted in chapter 3, was found to be the main reason for lack of adherence to such treatments in a qualitative synthesis and which was summarised as 'resistance' (Pound et al, 2005). Danforth and Navarro's (2001) theme of 'alternative solutions of a real problem' and the use of alternative approaches reported elsewhere (e.g. by Malacrida and Rafaolvich) indicates that this is a significant area in ADHD. The particular circumstances where medication is controversial and involves young children as in ADHD are clearly unique and which require further study.

The Contributions and Limits of Critical Approaches to ADHD

Critical approaches to ADHD, following many assumptions central to social constructionist ideas, have emphasised the limits of the individual pathology model and developmental psychology underlying ADHD, as well as drawn attention to current educational practices which have contributed to such conceptions. Critical approaches in varying guises have taken issue which such assumptions in a range of contexts and which have appeared as prolific and compelling arguments. Attention to the historical and cultural emergence of ADHD has also meant that ADHD has been viewed, not as a progress of modern science, but due to a number of social influences such as the rise of the pharmaceutical industry for example. The sociological process of medicalisation is useful because it places the focus on how such increasing labelling of children's deviance occurs and draws attention to the social, cultural and subjective aspects involved in clinical diagnosis of ADHD. These arguments are compelling and sociological contributions by Conrad, Malacrida and Rafalovich offer a valuable contribution and challenge to the dominant biomedical construction of ADHD. Such contributions are not without their limits however.

The sociological origins of Conrad, Malacrida and Rafalovich's work has meant that the emphasis in the area has largely been on illustrating broad theories such as in the process of medicalisation. Empirical data, from research interviews for example, has largely been used to elucidate such theory. The main limitation, therefore, with such work has been over the emphasis of the social influences over the individual. Conrad's (1976/2006) work had the overall aim of examining the process of medicalisation and which used hyperactivity as an example. Malacrida and Rafaolvich's emphasis variously employed a Foucauldian discourse analysis to consider mothers (Malacrida) or parents, children, teachers and clinician's (Rafalovich) perspectives in relation to broader sociological critique of current ADHD practices. The main critique with Foucauldian discourse analysis generally (and other top-down approaches like the Critical discourse analysis used by McHoul and Rapley, 2006) have been over its focus on social and theoretical aspects. In terms of the analysis of interview materials, such theoretical approaches have been accused of imposing theoretical constructs on to the data and with the failure to pay specific attention to the details of empirical data. There has also been a tendency of rendering the participants of such research, as passive agents in talk, or bearers of discourse (i.e. the so called 'death of the subject' in which the individual speaker in discourse analytic studies are constituted by powerful, all encompassing discourses). Others have taken issue over this interpretation of Foucault's work for discourse analysis (e.g. Lupton, 1997), but in general the tendency has been to privilege the social or discourse at the expense of the individual speaker. There have also been criticisms over the use of Foucauldian discourse analysis for interview data as opposed to textual data from which it was originally derived (e.g. Wooffitt, 2005). These general criticisms of Foucauldian discourse analysis for Malacrida and Rafalovich's contributions may be regarded as having limited applicability, however. Both analyses were concerned with the parents as active agents and not merely the pawns of powerful discourses. For example, Malacrida (2001) highlighted maternal strategies in relation to ADHD and Rafalovich (2004) highlighted the parental efforts at educating others about ADHD and which served to empower their efforts. Despite this, there was limited attention in these analyses to the empirical data and instances of local discursive practices. The benefit of such inductive attention to everyday talk about ADHD is clearly that it represents actual social practices of ADHD and this was limited in these analyses.

In addition and related to the above critique, such analyses as discussed above have tended to focus on feminist analyses of mothers in relation to ADHD (e.g. Malacrida, 2003; Bennett, 2003; Blum, 2007). This forms part of a larger critical body of work which has considered mothering children with disabilities (as highlighted in chapter 3). The limits with a feminist analysis in the area of ADHD are largely to do with the privileging of the maternal, which was found to be a weakness in previous research (seen in chapter 3). It's argued that, while valuable, this serves as a form of reification of the central role of the mother in ADHD, large at the expense of others and obscures such contextual influences.

In contrast to the above, 'bottom up' approaches to discourse analysis in ADHD, such as in conversation analysis, are also considered unsatisfactory. The neglect of the broader social and cultural context and how it may impact on language use is not given scope. As a cultural and socially available resource, language is considered as a tool to be mobilised by the individual speaker. Historical and ideological bases to language are also not given scope in these fine-grained approaches. In health and illness, for example, Radley and Billig (1996) emphasised the argumentative and ideological basis for accounts about this topic. The focus on purely 'technical' aspects is not conducive to the broader consideration of contextual and ideological issues about ADHD (Wetherell, 1998). The tendency of privileging the data and the interaction at the expense of the broader context and ideology has been considered unsatisfactory by critics. This focus in discourse analysis is also reminiscent of the individual-society dualism where the emphasis on interaction and talk-in-interaction amounts to a form of privileging the individual speaker. Hence, McHoul and Rapley's (2006) mixed approach employed a conversation analysis with a critical discourse analysis in the case consultation order to overcome some of the methodological challenges associated with the approaches.

Finally, the epistemological consideration of the privileging of the individual pathology models in ADHD was seen as an underlying assumption in biomedical and biopsychosocial approaches (as reviewed in chapter 2). It is argued further, that an emphasis on individual subjective experience is a further reification of the privilege of the individual at the expense or challenge of the social (as highlighted in chapter 3). Sociological contributions in the area of ADHD have been a valuable challenge to the biomedical paradigm. However, there is the tendency to privilege the social aspects at the expense of the individual. In discourse analytic studies similar Cartesian dualism occurs (Burr, 2003). Malacrida and Rafalovich's approach,

following critics of Foucauldian discourse analysis (and Critical discourse analysis), have emphasised broader social and theoretical concepts at the expense of a focus on the actual details of the empirical data. A purely fine-grained analysis is equally unsatisfactory in the area of ADHD (e.g. McHoul and Rapley, 2006). Thus, echoing arguments from Wetherell (1998), it is clear that discourse analytic approaches which transcend such dualism of the individual speaker versus the social context are required in order to provide an adequate and rich analysis in ADHD.

Methodologically, there are particular areas requiring attention in the field of ADHD. There has been a limited focus on including teachers in the research. Malacrida's research suggested that this was where the greatest conflict existed for parents. Rafalovich's research highlighted that teachers were increasingly engaged in the process of medicalisation. However, in an 'incompletely medicalised' context such as the UK, this would require further analysis. Danforth and Navarro's work highlighted the significance of everyday talk about ADHD and indicated the contradictions for lay people. Clearly the use of language events by the research assistants was an indirect way of studying actual talk. Insights from ethnomethodology and conversation analysis have highlighted the importance of studying everyday talk as occasioned and available for analysis. Such talk indicates actual instances of how lay people make use of language about ADHD. Thus it is possible to extend the insights provided by medicalisation theorists into actual talk in order to study such complex processes as how parents and teachers experience medicalisation and the helpful and less helpful aspects of this (i.e. Lupton's 'phenomenology of power relations'). This means that such processes can be considered in relation to actual instances of lay talk about ADHD. Further, health policy and practice for ADHD can be examined in relation to actual social practices by lay people.

Conclusion

The argument thus far has been concerned with highlighting the limits with an individualistic approach to ADHD as well as a purely social view as both approaches maintain Cartesian dualism. It was shown that a form of biological reductionism remains in biomedical approaches to ADHD and that a form of this reductionism remains despite greater attention to the social and psychological aspects of ADHD, or alternative and complementary approaches which essentially maintain the biomedical construct of ADHD (chapter 2). These approaches have a limited

conception of broader social, cultural and historical perspectives to ADHD which are involved in the increasing labelling of such behaviour. While valuable, humanist or phenomenological approaches add insight and greater understandings of the experiences of those affected (e.g. such as parents in chapter 3), however, what they do not do is to challenge the individualistic construction of ADHD itself and in fact may reinforce notions of individual child pathology in their focus on individual experiences at the expense of the social processes involved in such labelling (i.e. language) (chapter 3). Sociological contributions have emphasised broader social, cultural and historical influences in the emergence of the ADHD 'discovery' and provide a valuable (although perhaps marginal) counter to the biomedical constructions. Such aspects as the medicalisation of children's behaviour as a form of social deviance and medication as a form of medical control, as well as institutional and clinical practices which support such medicalisation are valuable in bringing attention to wider aspects that are generally neglected in ADHD (the focus of chapter 4). Such sociological processes and the emphasis on broader socio-cultural and historical influences are important in a critical perspective in ADHD. However empirically, the limits with research utilising such arguments may be with the tendency to reify such theoretical and sociological processes at the expense of the empirical data from which it arises. Hence there may be a tendency to privilege the social in such discursive research. It is argued that in order to study such processes as medicalisation and health policy as ADHD, it is necessary to focus analysis on the everyday talk and social practices about ADHD. How such lay people talk about ADHD is available for study. Clearly, then discourse analysis which attempts to transcend inherent dualism and which pays attention to the individual language user as well as the cultural context which produces language in ADHD is required. This allows a richer and fuller analysis and may extend insights from theories about medicalisation and understandings of lay experiences by the attention to actual practices and instances of talk by parents and teachers. This forms the focus of chapter 5.

Chapter 5: Methodology

Introduction

This chapter gives an account of the research process. It outlines the data, methods, analytic procedures and stance adopted for this study. The overall aim of this chapter is to present a transparent account of the research process. The issue of transparency is endorsed here in Cheek's (2004) 'decision-making' terms for discourse analysis and in relation to her claim that such analysis appears as a marginal field in qualitative research. It is recognised that the methodological procedures in a research study have implications for the assessment of that research according to issues of 'quality'. Although such notions in qualitative research are a contentious area, it is generally accepted as an important area to address. The methodological aim here was to produce a transparent account of the research along with the more overall aim of producing a quality analysis (i.e. an account considered persuasive, coherent and valuable, for example Taylor, 2001). Thus this chapter presents a chronological sequence of the research process in order to allow reflexivity. These methodological goals – transparency, reflexivity and quality of analysis – are considered consistent with the overall eclectic version of discourse analysis adopted for this study. This 'critical discursive psychology' approach (Edley, 2001) is outlined and regarded as beneficial for the area of ADHD because it enables attention both to issues of contemporary ideology and inductive empirical claims. Thus, it offers an approach which is able to theorise the problematic relationship of the individual speaker within the cultural milieu and thereby transcend problematic dualisms inherent in discourse analysis.

Research Area

This research study was an empirical exploration of lay parent and teacher accounts of childhood ADHD in a local area of Scotland where diagnoses and medication use were higher than other areas. Parents and teachers were the focus of this work because of the central role that they play in defining and monitoring children's behaviour. Increasingly, they are involved in the identification of problems and referral for ADHD assessments. The approach taken in this study is that the topic of ADHD may be explored as a discursive topic for these adults rather than as a

medical object. The 'problem' of ADHD, by this token, is therefore shifted to a discursive problem that requires negotiation in everyday talk rather than a problem of individual child pathology or a problem of widespread sociological influences. How a construction of ADHD enables and constrains talk for parents and teachers is important because of its implications for what can be experienced. The focus on local and everyday talk about ADHD in this manner has implications for debate about how children's difficulties are conceptualised as such and for what can be done about these difficulties. In view of the rising number of ADHD diagnoses expected in the UK, this is a particularly topical area.

Methodology

The following section outlines the main methodological areas involved in the present study. It considers: the background to the research; issues of ethics and access; recruitment procedures; sampling and data collection; transcription assumptions and conventions adopted; the discourse analytic approach adopted, the rationale for an eclectic version of discourse analysis and finally a specification of the analytic framework utilised in the analysis as outlined by Edley (2001).

Background to the research

This research took place in a local health authority in Scotland. This area is considered to have average or below average levels of poverty compared to other areas of Scotland; according to the NHS Quality Improvement Scotland Audit (2007). As a local health authority, the region had particularly higher rates of the use of psychostimulant medication for children diagnosed with ADHD, as was indicated by Quality Improvement Scotland's Health Indicators Report (2004). This report highlighted the disparate figures for medication use across the different health authorities in Scotland. In 2003, the prescription rates for methylphenidate here were double the national average for Scotland. As a consequence, the report generated considerable controversy and public interest. An audit was commissioned by the NHS Quality Improvement Scotland to investigate the care and treatment of children diagnosed with ADHD across Scotland. The first part of this audit was published in 2007, as mentioned in chapter 2, and further publications are expected in 2008. For reasons of confidentiality and to protect the anonymity of the people involved either directly or indirectly in the research, this area remains anonymous.

As an area, then, with high diagnoses of ADHD and the subsequent use of psychostimulant medication, the region appeared to be an important area for study in which to investigate talk about ADHD as it is an area where ADHD appears more frequently. The rationale for this was that if diagnoses of ADHD continue to rise in the UK, as is expected, then other local health authorities in Scotland may be able to learn from the possibilities and constraints which such a diagnosis afforded. By focusing on an area where in sociological terms, the medicalisation of children's behaviour occurred frequently, further consideration of how such medicalisation is helpful or less helpful, was possible. A Scottish context was also warranted in view of limited work in this context for ADHD.

Prior to this research I had been involved in working on an evaluation of an intervention for ADHD in a different local health authority area in the NHS. Thus, although I was not based in the local health area of interest, I was able to establish links with a local charity that provided holistic support to families that were affected by attentional difficulties. The mission statement on the charity's website indicated that it was committed to developing holistic support and information services to families for ADHD-type difficulties. There were over three hundred families registered with the charity at the time of the research, with varied involvement with the charity. The charity's activities ranged from a quarterly newsletter with advice and tips; news; an information resource centre; monthly parent support meetings in various locations across the region; social activities such as Christmas parties; non-medical interventions and advice such as fish oil supplements and dietary advice, food tolerance testing, and homeopathy. During March 2003-March 2006, the charity received funding from the Scottish Executive's Changing Children's Fund, and during this time had links with clinical psychology. After March 2006, funding was reduced and thus the activities of the charity had to be reduced. The users' of the charity included those parents and families that opted to try complementary therapies with, or as an alternative, to medical approaches as offered by the NHS.

Ethical Procedures and Access

Medical ethical procedures

At an early stage of the research, I established that ethical approval was required from the NHS Research Ethics Committee. This was because ADHD is currently

conceived unambiguously as: ‘medical research’ (Chairman of Health Research Ethics Committee, personal correspondence, 2004). Thus approval was sought from the Central Office of Research Ethics Committees (COREC). This was an extensive and involved process and entailed that copies of consent forms, information sheets and interview topic guides be developed in advance of the research and according to specific protocols in the NHS. While there have been many improvements in the application process since it has become centralised, the application forms and the specification of protocol are still heavily oriented towards research involved with clinical trials. The application form and procedures seem ill-designed for a qualitative study and particularly one using discourse analysis. Initially, I applied for multi-site ethical approval in order to broaden the areas in which I could potentially conduct the research, in view of potential difficulties recruiting participants.

I attended the Research Ethics Committee meeting on the 5 July 2005, as invited, where this application was considered. A provisional favourable ethical opinion was granted at this meeting. Minor amendments were required to the consent forms and information sheets in accordance with NHS protocol. As this meeting consisted of both lay and professional members, a preference was also expressed there for the clarification of a few points in lay language. A favourable opinion was received on the 19 July 2005. As a condition of this approval, it was necessary to obtain Research and Development management approval for the research in order for it to take place in local areas. This entailed two applications to local NHS areas and approval was given for these. No work actually involved NHS staff or took place on NHS premises and thus I did not require an honorary contract with the local area. Although it was my initial intention to obtain such a contract so that I could potentially work with a greater number of participants (e.g. staff and recruit participants on the premises), this entailed finding an NHS supervisor in two different sites, which I was not able to do in the timescale for the research. One local area became the focus of the research.

In keeping with this approval, informed consent procedures with both verbal and written information being given to the participants, as well as opportunities to ask questions about the research were secured. All participants included in the study involved adults who were capable of giving signed consent. Anonymity and confidentiality for the participants was also given (see the APPENDICES for the information sheets, Appendix 1 and Appendix 2; and the consent forms used, Appendix 3 and Appendix 4). Although the COREC application included details

about the inclusion of teachers as participants, separate approval was required for this. Finally, COREC approval rested on annual progress reports for the study and a final report of the findings.

Educational approval

In addition to the above ethical approval from COREC, I obtained education approval from the Director of Education in two education authorities. I submitted information about the study as well as copies of the consent form and information sheets that would be used for the teachers. Education approval for schools and head teachers to be approached and invited to take part in the research was given. This approval rested on the discretion of the head teachers' and individual teachers' willingness to participate. Educational approval was a relatively straightforward endeavour and one of the authorities appeared interested in receiving feedback from the research as: 'your work will be of great interest to colleagues' (Education Principal Officer, personal correspondence, 2005).

Collaboration with the voluntary sector

The initial links made with a holistic charity in one of the local areas, had indicated that this organisation was willing to be involved in the research. Once I had obtained ethical approval from COREC, I provided the charity with copies of documents developed for the research including: posters, consent forms and information sheets.

Recruitment

The local context

The local charity was approached about the research, and allowed posters about the research to be placed on the premises, online and to be circulated at parent support meetings (see APPENDIX 5 for the poster). Posters asked for volunteers and gave brief information about the study as well as contact details of the researcher. I was invited to attend four parent support meetings in order to distribute

posters to parents directly and answer initial questions about the research. The rationale for advertising the research at the holistic charity was twofold. Pragmatically, this provided me with a link towards recruiting participants in the local area as my area of interest. This was important as prior to this I had experienced difficulties with forming links in the local NHS area. The other reason was because of the specific characteristics of this group. Initially I considered that participants from a holistic charity may have been more likely to be able to offer alternative, non-medical accounts of ADHD and their child's behaviour than purely medical explanations which may have appeared if I had recruited through the NHS. Thus, the potential arose to analyse the talk of participants from a holistic charity and to consider what alternative explanations they were able to offer to mainstream medical ones. However, I recognised the limitations of this initial assumption. Firstly, that once it becomes possible to talk about a specific object such as 'ADHD', it is difficult to construe it in terms that do not in some ways refer to the medical. Secondly, in view of the widely reported use of alternative approaches by parents of children with ADHD in the literature (e.g. Bussing et al, 2002) such a sample may have been representative of parents in general. Thus, the choice of participants from the charity was largely pragmatic and may have been limited in its potential to explore alternative ways of talking about this topic.

A participant observation

Attendance at the four parent support meetings provided an opportunity to become familiar with talk about ADHD and holistic support. It provided an opportunity to be involved in parental talk about issues and topics that were considered important to parents and charity staff. I wrote notes detailing the topics that were covered in these meetings. These were then examined to see the main discursive patterns. From these meetings it was clear that the main focus in parental talk at the meetings had been on what could help for ADHD. This centred around two areas: medical treatments and holistic treatments. It was clear that while parents had been attending a holistic charity for ADHD-type difficulties, for many of them medication still remained as the dominant form of treatment. Perhaps unsurprisingly, this was a controversial area at the meetings. Attendance at these meetings also informed the later development of the interview schedules.

In addition to attendance at these meetings, a chance meeting with a local taxi driver during my work in the area, revealed a contrasting view to those of the parents. A local taxi driver in the area expressed his own (unsolicited!) views on the topic of ADHD in colourful language by stating that he thought it was due to the parents being 'fuckwits' and abusing alcohol and so it was 'a chemical thing' in lower states of society. This taxi driver had had experience with boys with ADHD because his company drove pupils to school everyday. He maintained that previous companies had been unable to cope with the boys but the present company had been successful. According to his anecdote, he was able to manage the boys in the taxi by putting on a DVD for them to watch, by chatting and listening to them, and by just generally treating them like human beings. He added that whether or not the boys had had their medication, they were 'bouncing off the walls'. (Permission to use and include his views was obtained). The purpose of including this anecdote is merely to indicate this contradictory perspective held by others in the community such as this taxi driver, which were circulating about ADHD as a controversial topic. Finally, two initial interviews with mothers, which lasted between 2-3 hours, also highlighted the emotionality expressed during the interviews (i.e. distress, anger, worry and fear). This is in keeping with the qualitative research review findings, as shown in chapter 3, and previous literature in ADHD which indicated the significance of parental, particularly maternal, emotional distress and health for parents of children with ADHD. Thus, it was clear that sensitivity and empathy in the research interviews was needed on this topic and it was something that I consciously strove to attend to in these interviews.

Finally, my attendance at two national conferences on ADHD in 2006 (a medical conference and a parent-support group conference) provided information, references and other sources of information currently circulating about ADHD in a UK context. Involvement with the participants of the study also provided additional sources of information relating to current books, assessment tools etc. as used by the participants.

Participants and sampling used

The sampling method

This research used a combination of theoretical sampling, convenience sampling and snowballing in order to arrive at a sample of parents and teachers. Theoretical sampling was considered important in order to reflect a range of theoretical constructs in the ADHD literature. During recruitment, participants were monitored in terms of demographics such as: socioeconomic status, marital status, age, occupation, gender and ethnicity. Theoretical constructs that were considered relevant to this study included: parents of girls diagnosed with ADHD; parents that refused medication as a treatment for their child; fathers of children diagnosed with ADHD and teachers of pupils diagnosed with ADHD. From the literature, as seen in chapters 2, 3 and 4, I considered these theoretical constructs to be neglected and therefore important to reflect in the sample in a study of the discourses available for ADHD. However, while these aspects were considered important and relevant to the sample obtained, and while I did monitor the sample in terms of the above theoretical constructs, ultimately control of the sampling was limited because it relied on volunteers.

Description of the participants

All participants came from the same health authority area in Scotland. Exclusion criteria at the start of recruitment were that parent participants needed to be residents in the area since the research was concerned with investigating talk about ADHD in this specific cultural context. All participants satisfied this criterion. Families also needed to have a diagnosis of ADHD for their child, rather than an unspecified behavioural or emotional difficulty. One volunteer (a grandparent) was excluded on this basis due to the unspecified nature of the child's difficulty. The rationale for this was because I was concerned with talk about the same discursive topic and participants' accounts relating to 'ADHD' as it is currently defined in biomedical terms. This was important because I wanted to explore talk about this topic. Participants also needed to be competent English speakers because the study relied on research interviews, again all participants satisfied this criterion. This is

also significant because a discourse analysis relies on participants' use of discursive resources in talk about a topic and so depends on everyday language use.

Parent participants

A total of twelve parents with children diagnosed with ADHD were recruited from eight families. Six volunteers were recruited through my attendance at the local parent support meetings along with their two spouses; three had seen the poster advertised on the charity's website and one had seen the poster on the charity's premises. The parents had had varied contact with the charity's services and ranged from very little contact (i.e. had seen the services advertised online) to regular contact with the charity over a number of years.

Of the twelve parent volunteers, eight were mothers of children with ADHD and four were fathers; one couple was a guardian relation. Nine parents were married or living with a partner and three were single parent families. All parents were white and all had experience of ADHD in the local area. Six working and six non-working parents were included in the study. Both middle and lower socioeconomic groups were represented in terms of professional occupational status. Parents' ages ranged from 24-54 years old. Nine parents were using medication as a treatment for their child and three parents had refused medication. The ages of the children ranged from five to twelve years old, with the majority under the age of eight years old. Two families had one child only while the majority had more than one child. One of the families with one child indicated that they were not planning on having any more children due to the demands that the child diagnosed with ADHD had placed on them. One family in the sample had more than one child diagnosed with ADHD, as a step-family. All the children were boys with the exception of one girl. All children had received a diagnosis of ADHD. Seven families had been in contact with the same paediatrician in the area. In sum, the sampling for the parent participants was considered to be successful in terms of obtaining a varied sample by including working parents, families refusing medication, fathers of children diagnosed with ADHD, and the parents of a girl diagnosed with ADHD. Parent participants received a pseudonym during the recruitment and care was taken to remove information that was personally identifiable or that identified other people or places in accordance with ethical guidelines. For instance: all children referred to by the parents received a pseudonym as did the names and places for health staff.

Teacher participants

Snowballing was utilised in order to recruit schools and teachers into the study. Parents were asked permission in order to contact their child's school and head teacher on the consent form. Where this permission was given, head teachers were approached and invited to take part in the study. As guided by the education approvals obtained, taking part in the study was entirely at the discretion of the head teachers. I also allowed the head teachers to decide on which teachers I would interview as it became apparent that access to teachers required such approval and facilitation from management. Seven families agreed that I could contact their child's teacher/school. One family did not agree because they felt that the teacher/school had a completely different view of things and preferred that I did not contact the school. While this may have made a very interesting study, the participant's wishes and consent remained the guiding priority for the research. Other schools were then also randomly contacted and invited to take part in the study that had had no connection with the parent volunteers. One school was recruited in this way. At the outset of this snowballing, I became aware that it was necessary to emphasise to parents and teachers that the aim of talking to the teachers was *not* to ask questions about a specific child diagnosed with ADHD, but rather general questions about ADHD at school and in the classroom. Many parents indicated that they thought teachers and schools held very different views about ADHD and that they 'didn't believe in ADHD'.

Ten teachers took part in the study from six schools. Nine teachers came from primary schools in the area and one teacher from a large high school. Five primary schools were represented and comprised two small rural schools and three larger town primary schools. Two teachers were male and eight were female. All schools were mainstream education schools as is expected due to Inclusion education policies. Both new teachers and experienced teachers were represented. The sample consisted of two head teachers, two deputy head teachers, two subject specific teachers, three classroom teachers and one learning support teacher. The sampling was considered to be successful in terms of representing a range of teachers, schools, gender and teaching experience. Teacher participants and schools were also anonymised through the use of pseudonyms for the individual teacher participants as well as the participating schools.

Method of data collection

The semi-structured interview

The semi-structured interview method was the primary method used for data collection. Interviews are widely used in social science research and have a number of benefits for research. Semi-structured interviews are useful as a means of obtaining rich and detailed data in qualitative research and allow an in-depth exploration of the participants' talk for discourse analysis. Further, for a discourse analysis, the research interview allows the researcher a means of analysing and collecting talk about a topic such as ADHD in order to explore patterns from a range of participants. Open-ended questions in the topic guide facilitate a more conversational style of talk by participants to enable the interview to be led by the participant rather than solely by the researcher's agenda. Here the choice of the interview method was also a pragmatic one relating to issues of access to participants in order to study the phenomenon under study.

The Parent interviews

Ten interviews were held with the parent volunteers. Eight were one-to-one interviews and two were joint interviews in which both parents were present at the same time. Although the individual interview was the preferred method of choice, joint interviews were at parents' request. Eight interviews took place at participants' homes while one interview took place at the holistic charity's premises and one on university premises. As indicated by the information sheets, parents were given a choice of their preferred location for the interviews. One joint interview took place in the home and was continued later by telephone with a father who had left for work. The advantages of conducting the interviews at participants' homes were to allow an informal and conversational style of dialogue with the researcher. This was considered to be important for a discourse analytic study where the focus is on such everyday language about ADHD. Home interviews may have allowed greater rapport with participants to be built as parents were interviewed in their own environment. Power imbalances between researcher and participants may have been somewhat alleviated in this way as it was the researcher who was in an unfamiliar environment. Further, home interviews may go some way in addressing

critique about the research interview as an artificial construction by the researcher. Some disadvantages with the home interviews amongst families with a child diagnosed with ADHD are the lack of control by the researcher of the interview setting for noise and disruption. Several interviews conducted in the home were interrupted by children, telephones etc.

The Teacher interviews

Nine interviews were held with the teacher volunteers. Eight were individual one-to-one interviews while one was a joint interview with two teachers present at the same time and which had arisen opportunistically. All teacher interviews took place on school premises. The advantages of conducting the interviews on school premises meant that teachers were in a familiar environment which, again, appeared to encourage easy and informal dialogue. Another advantage was that it maximised the potential for including the teacher volunteers. As busy professionals, with very narrow breaks and schedules in the school day, it allowed inclusion of the teachers. The disadvantages of school interviews, like the home interviews, were the lack of control by the researcher of the interview setting and the general noise and disruption in these environments (e.g. pupil disruption, bells and telephones). Limitations on teachers' schedules also meant that interviews had to be adapted according to the demands and constraints of the teachers' available time in which to take part in the study.

Interview procedures

Participants were assured that what they had to say was valuable and useful in an effort to dispel the idea of 'right' or 'wrong' ideas about ADHD. Interviews lasted approximately 1-2 hours for parents and one hour for teachers. Interview schedules were used for the purposes of eliciting talk about ADHD (see the APPENDICES for the topic guides used, Appendix 6; and the subsequent interview schedules, Appendix 7 and Appendix 8). Probing of participants' talk allowed further elaboration and exploration to occur on the topics and themes initiated by the participants themselves. Thus considerable flexibility was exercised in following participant topics. Nevertheless, the schedules facilitated talk on the following areas for

parents: definitions and meanings of ADHD; origins of childhood ADHD; talk about diagnosis and treatments; talk about interactions with health professionals and with school; managing ADHD-type behaviours at home and at school; fears and concerns about the future; other peoples' reactions and the media; parental health issues. For teachers the following areas were used to elicit talk: definitions and meanings of ADHD; origins of ADHD; talk about schools involvement for diagnosis and treatments; interactions with parents; managing ADHD-type behaviour in the classroom; and issues of concern for teachers about ADHD.

Each interview session was preceded by verbal information about the study and provided an opportunity for the participant to ask questions. The written information sheets were given to the participants and all participants were asked to sign a consent form in accordance with ethical procedures in the NHS. Demographic questions were asked in order to monitor the sampling procedures. Participants were then informed that the tape recorder/digital recorder was being switched on. This served to initiate the interviews. When the interviews were closing, a debriefing session was used which served to signal the closing of the interview (i.e. "Thank you for your time…"). It also provided an opening for participants to expand on any issues that they had not been given an opportunity to do (i.e. "Is there anything we haven't covered that you would like to talk about…"). Finally, in the parent interviews, I was aware of possible parental distress - as revealed in the initial interviews and the literature on parental health and ADHD. Hence I was conscious of reflecting on parental involvement in a research interview for ADHD and being sensitive to parents' narratives of their children's illness/difficulties and the controversial status of the diagnosis. Thus I asked parents at the end of the interviews "Can you tell me what it's been like talking to me today about your experiences". This allowed researcher reflexivity but also contributed to the closing element of the interview.

Transcription

Transcription assumptions

All research interviews were analogue and/or digital recorded and transcribed verbatim by the researcher. A simplified version of the conventions developed by Gail Jefferson (Atkinson and Heritage, 1984) was used for this study (see

APPENDIX 9 for the transcription conventions used). The full Jefferson transcription consists of the inclusion of such details as timed pauses, overlapping speech, in and out-breaths, the ordering of turns, emphasised syllables, interruptions etc. which has recently been updated (Jefferson, 2004). It is recognised that the relevance of these conventions are designed for a specific form of fine-grained analysis (i.e. such as conversation analysis). They are not typically used, nor relevant, for analyses which are concerned with broader patterns or contextual aspects of the analysis. While this does remain a contentious area in discourse analysis, with some arguing for the greater adoption for these conventions regardless of the type of analysis (e.g. Potter and Hepburn, 2005), the transcription process here was deemed sufficient for the analytic purposes of the study (which are detailed below). This is in keeping with others in qualitative research that have argued for the reflexive use of transcription conventions to suit the analysis as opposed to their widespread adoption in all analysis (e.g. Smith, 2005; Holloway, 2005) and over such positivist connotations for the field generally (Mishler, 2005; Parker, 2005).

Transcription conventions

The transcription method adopted in this study therefore was a simplified version of the Jeffersonian method. The rationale for the use of this simplified method over the fuller transcription method, as highlighted above, was in keeping with the analytic goals. Broadly, the analytic goal was concerned with patterns of talk displaying participant orientations and in relation to the broader context of this talk. Ultimately, it is recognised that what is transcribed should be reflected in the analysis and thus the decision was made to include a modified version of the Jefferson system and which included basic features of talk such as: pauses (untimed), louder or emphasised talk, overlaps of talk. During the transcription process the data was also anonymised through the use of pseudonyms and participant numbers and by changing descriptions that identified actual people or places in accordance with ethical guidelines. During transcription it was also decided that talk would be represented verbatim as it was uttered and appeared to the researcher, in the local accent and dialect. For example: “I dinnae ken” was used rather than the equivalent in standard English of: “I don’t know”. Some punctuation was included in the transcripts in order to improve the readability of the transcripts (e.g. quotation marks were used when a participant made use of the reported speech of a third party).

Ultimately it is recognised that these decisions, from the level of transcription to the means of representation of the data, entailed decisions that are imposed by the researcher and which affect the analysis. It is recognised, however, that this is ultimately true in any analysis and the justification for these decisions should be explicit and justified.

Analysis

ADHD and Discourse Analysis

Previous research regarding the socio-cultural and historical emergence of ADHD and its subsequent place in contemporary culture was highlighted in chapter 4. The sociological process of the medicalisation of children's deviant behaviour as ADHD emphasised the increasing scrutiny by the medical profession in terms of the identification of difficulties and control by medication. A medical discourse of ADHD provides the framework for how it is possible to talk about children's difficult behaviour on a broad level. However, it is also acknowledged that language in everyday contexts is not passive and all encompassing. Instead, in any given context, individual speakers have at their disposal a number of potential ways of talking about a controversial illness and will negotiate and contest such talk in their own terms in order to fulfil particular functions. Discourse analysis is an important approach for considering the social processes about ADHD, specifically how language constitutes experience. An approach to discourse which recognises the relationship of the individual speaker within the broader social context is required as well as the constitutive role that language can play in shaping subjective experience. Thus subjectivity is both enabled and constrained by the discursive (e.g. Henriques, Hollway, Urwin, Venn and Walkerdine, 1984).

Discourse Analytic process

In keeping with the transcription process outlined above, the broad analytic process adopted was an approach which examined patterns of talk in the data employing an eclectic version of discourse analysis (as described below in the next section). The approach adopted here was informed by Gilbert and Mulkay's (1984) version of discourse analysis with its emphasis on the constructive and variable nature of

discourse. Potter and Wetherell's (1987) earlier and original formulation for social psychology is also significant with the emphasis on the action orientation of language, or its functionality in a given context, along with the emphasis on construction and variability.

The analytic process was a fluid one which occurred, like much qualitative research, not as a discrete stage at all but in conjunction with: conducting the interviews, transcribing the interviews, coding the data and during the writing of the analytic sections. The interviews, and particularly the lengthy transcription process, allowed for a period of immersion with the data. It was during this phase that discursive features of interest were noted for individual interviews. Once transcription was completed and checked, a process of reading and re-reading the transcripts occurred in order to extend ideas about discursive patterns and features of the data. Coding of the transcripts occurred by collecting segments of talk about the same topic (i.e. talk about the origins of ADHD). These were identified in the transcripts and prepared by cutting-and-pasting from single interviews into a collection of the same topic. This allowed data management and closer examination of the extracts which facilitated the identification of patterns across data extracts, although reference to the broader material was also made constantly. Colour-coding of extracts allowed such coding to be developed further. Analysis was iterative as it occurred after initial coding and then in light of developing codes and stimulated further reference to the data transcripts. The analysis also benefited from supervision input and once initial drafts of the analysis of the data were prepared, from peer feedback. The process of writing, rewriting and revising drafts of the analysis also formed part of the overall analytic process

Varieties of discourse analysis were outlined previously in chapter 4 where Wooffitt's (2005) distinction between 'bottom-up' approaches and 'top-down approaches' in discourse analysis were considered useful. In view of the array of positions in discourse analysis, it is necessary to specify and outline the approach used here. In contemporary specifications of discourse analysis, a mixed or eclectic version of discourse analysis is adopted here. The benefits of this form of discourse analysis are outlined below for studying ADHD talk.

Rationale for an Eclectic version of Discourse Analysis in ADHD

An eclectic version of discourse analysis provides a novel approach in the field of ADHD and in the analysis of talk about this topic. An eclectic position or mixed version of DA is a recent approach which utilises elements from both the 'bottom-up approach' as well as the 'top-down approach' as called for recently by Wetherell (1998) in response to unhelpful and stagnant polarities in the field. These polarities were viewed as increasing attempts to establish hegemony in the field for the study of talk; such as by conversation analytic principles as elucidated by Schegloff (1997). Schegloff's (1997) outline had resulted in debates in the field (e.g. the extended debates between Schegloff (1999a; 1999b) and Billig (1999a; 1999b) in *Discourse and Society*). However, Wetherell's (1998) argument provided a serious and persuasive challenge for the field by the innovative use of eclectic approaches in discourse analysis. Wetherell's (1998) argument was substantiated by reference to data from a joint project with Nigel Edley on men and masculinity obtained by focus groups with young men. Wetherell proceeded to demonstrate the limitations of a purely 'bottom-up' approach (i.e. through conversation analysis) as a 'technical' focus on talk-in-interaction for this data, as well as highlight the merits of an additional 'top-down' approach (i.e. post-structural analysis using Laclau and Mouffe). Wetherell highlighted how a 'portfolio of subject positions' were made available locally in the talk (i.e. Aaron as drunk; as lucky; as on the pull etc. to account for his escapades one weekend with various young women). The analysis further demonstrated how such culturally available subject positions, having been made available in the talk, were then negotiated, contested and constituted by the participants' orientations and turns in conversation. The significance of this work was to provide an empirically demonstrated argument for the merits of an eclectic approach in discourse analysis and has further stimulated eclectic use of discourse analytic methods which seek to offer rich, insightful and contextual analysis (e.g. Edley, 2001).

The eclectic version of discourse analysis is thus able to utilise a variety of useful concepts for analysis. From conversation analysis and ethnomethodology, the focus on studying everyday talk as empirical data in order to interpret lay or members' ways of understanding the world is important. The attempts by the analyst to ground analytic claims in participant orientations or what the participants are doing in the text is also considered useful (Schegloff,1997). This inductive process

in conversation analysis is a valuable means of attending to and demonstrating analytic claims. Analysis may also be interpretive or theoretical and draw from 'top-down' approaches. Here claims are made in reference to broader social, historical and cultural context in which such talk originates because of the recognition that talk both originates from and is limited by such contexts. Billig's (1991) conceptualisation is useful here for a mixed version of discourse analysis because the problematic relationship of the individual speaker and the cultural context in which they originate is able to be theorised. This is unlike other approaches in DA which also tend to maintain a form of Cartesian dualism in which they tend to privilege either the individual language user or micro talk (i.e. seen in 'bottom-up' approaches such as conversation analysis) or the broader, social and macro context (i.e. 'top-down' approaches and the 'death of the subject' in Foucauldian analysis for example) (Burr, 2003). In an eclectic discourse analysis, the individual speaker is recognised, by contrast, as both the 'product' of their cultural context, as well as the 'producer' of this context (Billig, 1991). In this view the individual speaker is seen as both limited and enabled by the language provided by a particular context. In other words, the individual will be capable of unique talk but always within the boundaries of their socio-cultural context (Edley, 2001). This position enables a far richer appreciation of the inter-relation between the individual language user and the broader context in which they exist. These philosophical considerations are important in the field of ADHD. Clearly the broader historical and socio-cultural context in ADHD is an important consideration in the emergence and maintenance of the ADHD construct (as highlighted in chapter 4). Thus analysis which fails to consider these aspects in talk, as is common in the medical approaches reviewed in chapter 2 more generally, is clearly unsatisfactory in its failure to theorise how such cultural contexts shape our experiences through the social processes they create.

It has also been argued that this version of discourse analysis offers a more humane and ethical approach in studying individual accounts of health and illness (for example Silverman (2000); Willig (2004)). This is because of the recognition of the complex inter-relationship between the speaker and context in health and illness. This is in contrast to some versions of discourse analysis which have either been criticised for rendering the individual speaker powerless in the face of all-encompassing discourses (i.e. as in the 'top-down' approaches) or by otherwise focusing on such technical aspects of talk-in-interaction, without a consideration of the context in which such talk is able to be produced in the first place (i.e. as in the

'bottom-up'). In the area of ADHD, an approach which pays attention to the context and origins of talk as well as the individual use of such talk is significant in order to offer understandings about what such talk allows and constrains. Such analysis offers a detailed understanding of the possibilities and limits of talk from a particular cultural context which in ADHD research has clearly been absent.

Further, in the area of medical discourse and communication an eclectic version of discourse analysis has received support from others (e.g. Gwyn, 2002) who have argued, following Wetherell, that such an approach in discourse analysis may be more fruitful for analysis and pragmatic in overcoming methodological disputes. Thus, Gwyn (2002) argued for the benefits of such an approach in offering a rich analysis and proposes an 'ethnographic discourse analysis' or a mixed discourse analysis as particularly pertinent for the area of medical discourse and health communication. This approach may be particularly important for studying talk about controversial 'illnesses' such as ADHD where competing discourses exist about this topic. How these competing discourses are taken up and used in local everyday talk may be the subject of further study. This work, therefore takes as its starting point, in keeping with Wetherell and others, the argument for an eclectic version of discourse analysis as providing a rich and contextual account. Such an account is one which seeks to ground analytic claims in the data by recourse to participants' orientation, while offering an interpretation of these orientations by recourse to wider social and cultural contexts. A mixed form of discourse analysis is an attempt, therefore, to do justice to empirical data claims and offer a contextual analysis of these claims. It may utilise the conversation analytic feature of grounding analytic claims in participants' orientations (Schegloff, 1997; Potter, 2003) but departs from this tradition in offering an interpretation of the broader contextual issues which impact on talk. Unlike in Critical discourse analysis, however, there is no a priori political stance taken because it is recognised that operations of power, for example in ADHD , may be complex and that speakers may be both empowered and disempowered by specific ways of talking. Similarly, unlike Foucauldian discourse analysis this approach recognises the ways in which speakers choose to take up particular ways of talking for a particular indexical purpose and to notions of resistance or counter explanation. Finally and in essence, an eclectic discourse analysis recognises the value of the conversation analytic claim of empirically demonstrating claims within the data, but also sees value in drawing on wider contextual issues and theory.

A 'Critical Discursive Psychology' Framework in ADHD

The analytic stance adopted here, as seen above within discourse analysis, was therefore an eclectic version of discourse analysis. The overall aim of analysis aimed to produce an analytic interpretation both grounded in empirical data and parent and teacher participant orientations but also one which took the broader contextual aspects and ideological notions of ADHD seriously. In addition to influences from Gilbert and Mulkay's (1984) formulation of discourse analysis in the sociology of scientific knowledge and early work by Potter and Wetherell (1987); Wetherell and Potter (1988), subsequent analyses by Edley and Wetherell (e.g. 1997; 1999) also informed this work in the sense of the arguments advocated for the utility of a mixed approach to discourse analysis. Specifically, Edley's (2001) analytic framework for a *Critical Discursive Psychology* approach is adopted. A 'Critical Discursive Psychology' approach drew from previous eclectic influences in discourse analysis. Thus it is rooted in arguments for an eclectic discourse analysis and offers a pragmatic outline for conducting such analyses. As highlighted above, this approach was deemed appropriate for the controversial field of ADHD because of its attention to empirical data claims and the broader context in which such talk occurs. The strengths and limits of using this method are reflected on in the discussion chapter. There are three analytic concepts which are central to this framework and which will be adopted here. These are discussed below.

The interpretive repertoire: Gilbert and Mulkay's (1984) notion of an interpretive repertoire in their analysis of scientists' discourse was utilised by Potter and Wetherell (1987) when they introduced the notion of the interpretive repertoire in psychology and defined it as: 'basically a lexicon or register of terms and metaphors drawn upon to characterise and evaluate actions and events' (1987:138). Work utilising the interpretive repertoire was employed in their earlier work particularly (Wetherell and Potter, 1988; Potter et al, 1990). Edley's (2001) revived use of the interpretive repertoire is as: 'relatively coherent ways of talking about objects and events in the world' (2001:198). The notion of the interpretive repertoire is useful conceptually as an analytic means of identifying relatively stable ways of talking about a particular topic or patterns of talk. Discourse analytic work that has made use of the interpretive repertoire has been diverse and included for example, work in community race relations (Potter and Reicher, 1987); an analysis of marriage talk

(Lawes, 1999); racist talk (Wetherell and Potter, 1988) and sexist talk (Wetherell and Edley, 1999). Others have also utilised the explanatory capacity of the interpretive repertoire, while focusing instead on 'discursive resources' in areas such as health and illness talk amongst older men (e.g. McVittie and Willock, 2006). The interpretive repertoire is valuable because it posits that there are culturally available ways of talking about topics that are able to be mobilised and utilised by speakers within the context of any interaction. Thus the notion implies that speakers have at their disposal any number of repertoires which are given to them through a particular culture or context and that how they make use of these repertoires is available and able to be studied in talk. There is less of a sense of an all encompassing discourse as in other forms of discourse analysis for example. It's also clear that the interpretive repertoire has proved useful and utilised particularly in relation to controversial topics and so is relevant for ADHD talk.

Subject positions: Althusser's (1971) notion of subject positions was used and introduced to psychology by theorists such as Henriques, Hollway, Urwin, Venn and Walkerdine (1984) and Davies and Harré (1990/2001). Subject positioning broadly refers to the notion that when speakers adopt a particular way of talking about a topic they are necessarily positioned by the talk in a particular way. Thus talk about a medical discourse for example, entails available positions such as 'doctor' or 'patient'. Or in a recent study in sociology, for example, Speed (2006) showed how talk about mental illness utilised various subject positions from the literature as 'patients', 'consumers' or 'survivors' in relation to the medical profession. Edley (2001) refers to this as 'locations' within a conversation. The concept of subject positions refers, therefore, to the available identities that are implied within particular ways of talking. These may have unintended consequences and are seen as temporal rather than referring to any enduring or stable notions such as a 'personality' in traditional psychology. The implication is thus that as conversations change, so too can the possibilities and the limits for a speakers positioning within talk. An exploration of the types of positioning that are available for speakers is therefore able to offer an interpretation of the possibilities and the limits which drawing on particular interpretive repertoires will have. This offers insight and understanding therefore of the social and psychological realities of the speaker, although notions of social and psychological 'reality' are construed very differently (i.e. not as a stable and enduring entity but as temporal).

Ideological dilemmas: Billig's (1987;1991) emphasis on the argumentative and rhetorical nature of talk is important in terms of its construction as well as the ideological notions influencing talk and discourse. Billig et al's (1988) notion of the ideological dilemma is significant here and refers to the fragmented and often contradictory nature of everyday talk and common sense. The ideological dilemma refers to a manifest dilemma in talk as a result of drawing on competing ideologies. Hence a common feature of talk is its dilemmatic nature by which the speaker is required to resolve during the course of everyday conversations. How such dilemmatic features are resolved is an important feature of talk available for study. Common sense maxims, for example, were highlighted as containing a number of contradictory elements and the example given of: 'too many cooks spoil the broth' and: 'many hands make light work'. Other examples of competing ideologies were further explicated relating to education: and the ideological dilemma exists between authoritarianism and egalitarianism; in health and illness: an ideological dilemma between belonging to society versus being marginalised or the desirability/undesirability divide was important. These ideological dilemmas required resolution and this resolution manifested in different ways and contexts. In controversial talk further, the notion of ideological dilemmas and the availability of competing ideologies may be particularly salient. The ideological dilemma is thus an important concept analytically as it recognises and traces the resolution of competing ideologies for everyday talk.

Conclusion

A Critical Discursive Psychology approach was used in the present empirical study in order to explore lay parent and teacher talk about ADHD in a particular area of Scotland. This approach utilises an eclectic discourse analysis and is useful because it is concerned with grounding analytic claims in the data, as in the conversation analytic principle of participant orientations, but at the same offers an interpretation of this data through reference to the broader, social and cultural context of ADHD. A further benefit of this approach arises from its epistemological point of view, which is considered particularly relevant to the field of ADHD. The eclectic discourse analytic position is beneficial because it is able to reconcile and theorise the problematic relationship of the individual speaker and the cultural context in which they reside. The philosophical theorisation of the individual speaker and the broader cultural context is particularly significant in ADHD. Clearly a lack of

reference to such broader historical and socio-cultural considerations (as reviewed in chapter 4) for analysis would appear unsatisfactory in its failure to account for such influences. Such neglect is typical in the scientific paradigm and medical approaches to ADHD (as seen in chapter 2). At the same time however, analysis that simply reinforces such broader concepts on the individual speaker, is equally unsatisfactory in its failure to consider the potential of individual speakers to contest and constitute talk about ADHD. Thus the eclectic version of discourse analysis exists as a potential approach which, in ADHD, exists to offer a satisfactory and rich consideration of both the individual speaker and the larger context. Edley's (2001) outline of a 'Critical Discursive Psychology' framework offers a pragmatic framework for a particular form of eclectic discourse analysis, as used in previous work, and is useful for considering the controversial topic of ADHD. This framework is utilised here and thus the analysis is concerned with the interpretive repertoire, subject positions and ideological dilemmas inherent in parent and teacher talk. Analysis of the empirical data is presented in chapters 6 and 7 based on this framework.

Chapter 6: Analysis of Parental Accounts of Children's Difficulties

Introduction

This chapter consists of an analysis of parental talk about their child's difficulties diagnosed as ADHD, from semi-structured interviews, following an eclectic discourse analysis. Edley's (2001) framework for analysis, as outlined in the previous chapter, was utilised for the analytic concepts of the *interpretive repertoire*, *subject positions* and the *ideological dilemma*. This analytic framework was useful for an eclectic discourse analysis in ADHD which aimed to study the culturally available resources for talking about ADHD for parents and how these were taken up and used by individual speakers. The chapter consists of four sections of analysis. The first two sections make use of Edley's (2001) analytic framework for considering parental talk and offered a useful way into the data. Consistent with this framework then, section one was concerned with the identification of interpretive repertoires in parental talk and the available subject positions these repertoires entailed, in accounting for the origins of the child's difficulties. These had competing implications for parental subject positions and thus section two was concerned with how parental talk succeeded in overcoming this ideological dilemma. Section three turned to an exploration of how parental talk attended to and managed competing views as held by others' (i.e. schools and family members), with parallels drawn here with classic findings from discourse analysis. The final section was focused on parental talk about the use of controversial medication (i.e. Ritalin) and what this talk entailed for positioning in relation to such medications.

Parental Accounts for their Child's Difficulties

In keeping with others that make use of the interpretive repertoire (Gilbert and Mulkay, 1984; Potter and Wetherell, 1987; Edley, 2001) two opposing but central ways of talking about ADHD were present in parental talk about ADHD. While these represented contradictory ways of talking about ADHD, it should be noted that parents drew on both ways at various points in the interviews. That parental talk, in interviews, displayed variability and contradictions is not surprising from a discourse analytic perspective. Indeed, as highlighted in chapter 3, variability and contradiction

in talk is considered to be a common feature for analysis. The use of a particular repertoire then can be considered to be a temporal and situated occurrence. The following data arose within parental accounts of their child's difficulties when parents were either prompted directly by the interviewer (i.e. *How do you think your child came to have ADHD*) or arising indirectly (i.e. *Tell me about your child; Who first noticed the difficulties).*Hence these extracts can be seen to be concerned with parental accounts for their child's difficulties which focused on the possible origins of the difficulties. The following extracts are presented for further analysis.

Extract 1

Parent Interview 5: Mrs McKay of Liam

I: Tell me about your child
P**:** um hum em Liam he was diagnosed maybe (.) two years ago (I: uh huh) and my my husband's got a son already my stepson and Liam was diagnosed so early because we seen the signs (I: ah) so they were able to (.) cos it's seventy percent (.) more common in boys than it is in girls (I: mhm) and it's obviously come from my husband's genes (I: uh huh) and they think he probably had it but it was never (.) there was never (.) there was never such a thing as ADHD (.) when he was a child (I: yes) cos he was always on the go as well (I: right) so we think that it's (.) well the doctors and that think that it's come from the man's side a' the genes

Extract 2

Parent Interview 4: Mr McKay of Liam

I: […] so how do you um think Liam came to have ADHD
P: (laughs) I'm told that it's through me (laughs) I'm told that it's through my genes (.) I was very hyper when I was (.) a kid but there thirty years ago (I: um hum) it was never recognised and my oldest son (.) () he's got it for a lot a' years (laughs) so (that's why Liam has it in his genes)

Extract 3

Parent Interview 8: Mr & Mrs McCormack of Gary [Guardians]

I: Tell me about your child […]
F: […] it was my sister was er (.) () the two a' them and she used to be quite a wild one as well when she was younger (I: so that was your sister) [Gary's biological mother] um (I: yes) so that's where it's all come from (I: oh right)
M: now we were just wondering we did ask Dr X if it was a chance that it could it could be the likes a' generic [genetic] (I: uh huh) and I think he says it's poss possible (.) when we asked that (I: mhm) that was a good few years ago we asked that (I: mhm) I don't know if things have changed and they're more certain but (.) as you said you can remember your sister when she was young
F: yeah she was (wild)
M: and it's just the same traits (I: oh right)
F: she was just a wild em (I: uh huh) a wild child um (.)

Extract 4

Parent Interview 9: Mrs Henderson of James

I: **Tell me about your child** […]
P: […] is there such a thing as ADHD or is it something (.) to do with when when the kids are born or (.) when my husband and I split up when James was about two and a half (.) something to do with attachment so I'm not very sure just now
I: what do you (.) what do you think
P: I'm not sure I'm kind of undecided at the moment (I: yes**) is it a biological thing or is it (.) is it to do with er (.) your up your social environment** […] I mean I hadn't heard anything about attachment before I did this course (I: mhm) didn't know about all these things (.) and I do wonder whether it has been something to do with attachment theory cos my husband worked away (.) a month and was home a month or before that he worked away (.) em ten days and home for a couple a' days cos he was at [name of company] and I was working full time so we always had somebody looking after the kids

Extract 5

Parent Interview 7: Mrs Wilson of Paul

I:[…] **so going back a bit who first recognised um** (.)
P: […] made you feel like you were doing something wrong like it was your fault like (.) it was because we split up (I: oh I see) that it has had an effect on Paul (I: oh) and that it was something *we* were doing wrong (I: mhm) that (.) cos after awhile of the nursery saying 'oh he's just a badly behaved child there's nothing wrong with him blad-dee-blah-dee-blah' you get it sunk into your head he's a bad child he's a naughty child

Extract 6:

Parent Interview 2: Mrs Roberts of Ian

I: Tell me about your child
P: […] I feel an important thing about em before having Ian is I was really *anxious* (I: um hum) all through my pregnancy […] and I don't know (.) I sometimes look back on it and wonder because of all the anxiety and stress (.) you know havin' a child that I wasn't prepared (.) for (I: mhm) () how's my husband gonnae react, how's my kids gonnae react […]so I don't know if that maybe had somethin' to do with the way Ian is

In the above extracts 1-6, there is evidence that parents are drawing upon two different interpretive repertoires to account for their child's ADHD. In extract 4 these repertoires are articulated by Mrs Henderson when she says in line 6-7: "is it a biological thing or is it (.) is it to do with er (.) your up your social environment" (as highlighted above). Here parental talk draws explicitly on a "Biological" Repertoire

and an “Environmental” Repertoire to account for the child’s difficulties and it will be argued likewise that these repertoires are present in the above extracts. As highlighted above, the Biological and Environmental repertoires are not considered mutually exclusive repertoires in these accounts. They are taken to represent two discrete and opposing ways of accounting for the child’s difficulties which occurred at various points in all interviews. It is not the case, therefore, that the presence of the repertoires was related to specific parents. Instead the above data extracts should be considered as illustrations of the wider availability of the repertoires which appeared in parental narratives. A further point to note is that when these repertoires occurred together as in extract 4, they were set up as a dichotomy and opposition (i.e. as an either/or possibility). Further, the extracts can be hearable as orienting to *past* origins for the difficulties. The Biological Repertoire will be considered first in the analysis, followed by the Environmental Repertoire as representations of two culturally available ways of talking about their children’s difficulties.

The ‘Biological’ Repertoire

In extracts 1-3 there is evidence that parents are deploying a Biological repertoire to account for the child’s difficulties. In this Biological repertoire, the child’s difficulties are construed in biological terms which implicate genetic origins. There is a clear orientation to a medical context for the child’s difficulties which characterise these extracts. Tied to this invocation of a medical context, three common discursive features can be observed across these extracts. Most noticeable, in the first instance, a genetic account is offered in order to explain the child’s difficulties. This is seen in the explicit: “it’s obviously come from my husband’s genes” (extract 1, lines 5-6); “I’m told that it’s through my genes” (extract 2, line 2) and “the likes a’ generic” (extract 3, line 6). Mrs McKay’s use of “obviously” invokes a straightforward and relatively linear causality for the child’s difficulties along with Mr McCormack’s statement in line 4:“so that’s where it’s all come from”, when describing his late sister’s behaviour. In comparison, Mr McKay’s version is less convincing through the use of “I’m told”, which implies a passive recipient of medical knowledge. His initial laughs in line 2 can be taken to signal the telling of something that is problematic or of troubles (Jefferson, 1984). In addition, Mrs McCormack’s: “we did ask Dr X if it was a chance that it could it could be the likes a’ generic [genetic] […] and I think he says it’s poss possible…” (lines 5-7), also appears less convincing here. Thus

although the certainty with the genetic explanation may be less pronounced here and differs in these extracts, what is significant is that it is readily available to be offered as an explanation for the child's difficulties. It appears as a dominant discourse with these extracts.

Secondly, the relevance of medical authority is invoked in these genetic accounts. In extract 1, line 2, Mrs McKay refers to: "Liam he was diagnosed maybe (.) two years ago". This occurs in response to the interviewer's general question to: "Tell me about your child". Thus the diagnosis (of ADHD) can be heard to be the significant aspect about the child here. Further in lines 4-6 Mrs McKay cites official scientific (although arguably contested) statistics over the prevalence of ADHD in boys: "cos it's seventy percent (.) more common in boys than it is in girls" with: "and it's obviously come from my husband's genes". In addition, Mrs McKay orients to a medical authority with: "and they think he probably had it …" (line 6) and: "so we think that it's (.) well the doctors and that think that it's come from the man's side a' the genes" (lines 8-9). With this orientation it is clear that the genetic argument is being presented as owned by the speaker (as seen in: "…we think…"). Noticeably, "they" and "we" are recognisable as referring to the medical profession and the parents who are being presented here as allied and of the same opinion. In addition, the repair from "we" to "they" may be significant with a shift from lay medical knowledge to expert verification. The effect is to defer to medical opinion, in this instance, to achieve credibility for a medical explanation rather lay opinion which may appear as a weakened explanation in the context of a controversial illness. In extract 2 (line 2) Mr McKay's: "(laugh) I'm told that it's through me (laugh)" occurs in response to the interviewer's question: "so how do you um think Liam came to have ADHD". The "I'm told that it's though me" can also be heard as a turn to a medical line of reasoning whereby a genetic explanation is offered and where medical authority is invoked later in the extract (i.e. "like what the doctor said"; not produced here). Finally, in extract 3 (line 5) Mrs McCormack's: now we were just wondering we did ask Dr X if it was a chance that it could be the likes a generic"(sic) is also a turn to medical confirmation for the difficulties. The invocation of medical authority in these extracts works to give support for a biological explanation.

Tied to the genetic explanations offered, and the turns to medical authority there is also an orientation to past family history in these extracts which work to strengthen the genetic explanations. Clearly what is significant here is that in extracts 1-3 such past family history is being actively constructed and offered in

ways which support a genetic explanation. Thus Mrs McKay talks about Mr McKay as being: “always on the go as well” (line 8). Mr McKay talks about himself as: “I was very hyper when I was (.) kid” (line 3), in support of a genetic explanation. Lastly, Mr McCormack talks about his late sister as: “quite a wild one as well when she was younger” (lines 2-3) and echoed again in lines 10 and 12. So past family members’ behaviour is being actively constituted in these instances in lay terms as: “on the go”, “hyper” and “wild” which function to give credence for the genetic explanation of ADHD as in keeping with the family history.

In summary, the use of the Biological repertoire entailed a genetic explanation for the child’s difficulties in extracts 1-3. In these extracts a medical context was invoked for the child’s difficulties. Characterising this medical context, there were three discursive features observed which functioned to support a biological origin for the child’s difficulties. Firstly, a genetic explanation was readily available in order to account for the difficulties (although it was noted that the certainty of these accounts differed). Secondly, medical authority was invoked in order to tie these explanations to expert opinion rather than lay belief. Finally, the family history was accounted for using lay terms such as “on the go”, “hyper” and a “wild one” and which was actively oriented towards providing anecdotal evidence in support of these genetic explanations. Thus, these features were seen to underlie use of the Biological repertoire in which the child’s biological constitution was deemed to be accountable for the difficulties. Furthermore, the constitution of the child’s difficulties as individuo-centred meant that the parents were able to construct such difficulties as external to themselves. This is taken up further later.

The ‘Environmental’ Repertoire

In extracts 4-6 there is a somewhat different construction offered for the origins of the child’s difficulties. Instead of a medical context being invoked in these extracts, a family context is hearable. Environmental explanations are hereby being invoked to account for the child’s difficulties. A range of environmental explanations are offered to characterise these extracts. In extract 4, Mrs Henderson’s: “is it something (.) to do with when when the kids are born or (.) when my husband and I split up when James was about two and a half (.) something to do with attachment…” (lines 2-4) cites attachment theory and parental divorce as possible considerations for her child’s difficulties. After the interviewers’ probe in line 5 (“what do you (.) what do you think”), the turn in line 6-7 of “I’m not sure I’m kind of undecided at the moment

(I: yes) is it a biological thing or is it (.) is it to do with er (.) your up your social environment" deploys both repertoires (as mentioned above). However two aspects are noteworthy here: while both repertoires are being invoked here, unlike the other extracts where one repertoire features, it is the Environmental repertoire which is given greater precedence through Mrs Henderson's orientation to detailing this repertoire and her later return to this explanation in line 7. The second aspect here is that (as highlighted earlier), the repertoires appear here as an either/or dichotomy: "is it a biological thing or is it (.) is it to do with er (.) your up your social environment" (lines 6-7). Thus these explanations appear as opposing and discrete. In extract 5 Mrs Wilson also orients to an environmental repertoire in line 2-3 with: "…like (.) it was because we split up (I: oh I see) that it has had an effect on Paul". Like in extract 4, parental divorce is being cited as an explanation for the child's difficulties. [It is useful to note that this explanation is temporal and made available by reference to the nursery's early assessment of the child's difficulties; within the context of the interview it appears in the narrative as the 'incorrect' view which is later superseded by the more 'correct' explanation of ADHD]. However, what is significant for analytic purposes here is that the environmental explanation is readily available to be offered as a possible explanation. Tied to this Environmental repertoire is parental accountability and responsibility as seen in: "like it was your fault" (line 2) and "that is was something we were doing wrong" (line 4). In extract 6 Mrs Roberts, like extracts 4 and 5, draws on an Environmental repertoire when she cites stress and anxiety during her pregnancy as a potential origin for her child's later difficulties: "I sometimes look back on it and wonder because of all the anxiety and stress (.) you know havin' a child that I wasn't prepared (.) for …"(lines 3-5) to account for "the way Ian is" (lines 6-7). In an earlier part of the interview – not produced here - Mrs Roberts invoked a Biological repertoire with reference to a "chemical imbalance in the brain". Hence what is significant in extracts 4-6 is that while they offer different explanations for the difficulties from one another, they are similar in the precedence that they give to environmental explanations (i.e. early attachment and parental separation, a stressful and anxious pregnancy). These explanations appear more complex in nature and are clearly marked from the linear causal explanations seen in the biological and genetic explanations in extracts 1-3. Finally, common to all these explanations is that they all feature aspects of the parenting and family context.

A second feature of analytic interest is the speculative and uncertainty characterising these accounts. Note the questioning format in extract 4 with: “is there such a thing as ADHD or is it something (.) to do with…” (line 2) unlike in extracts 1-3 where a statement format is adopted (i.e. “it’s obviously come from my husband’s genes” in extract 1, lines 5-6; “I’m told that it’s through me” in extract 2, line 2; and finally: “so that’s where it’s all come from” in extract 3, line 4). This questioning format is distinctive in challenging the utility of ADHD as an explanation at all in favour of such environmental explanations. Extract 5 can also be heard as largely speculative because although the Environmental repertoire features here, it is hearable as a tentative explanation which in the course of the narrative gives way to the ‘correct’ explanation of ADHD. Extract 6 also has a speculative quality with: “I sometimes look back on it and wonder…” in lines 3-4.

In addition to the questioning format adopted in extracts 4 and 6, and the presentation of ‘incorrect’ environmental explanations to be superseded by biological ones in extract 5, there are further characteristics relating to the presentation of these accounts. In extract 4 Mrs Henderson declares after her explanation of attachment and parental separation: “so I’m not very sure just now” (line 4). When the interviewer attempts to further probe this stance, she reiterates that: “I’m not sure I’m kind of undecided at the moment…” (line 6)” followed by: “ is it a biological thing or is it (.) is it to do with er (.) your up your social environment ” (line 7). The repetition of: “I’m not very sure” (lines 4, 6) emphasises the uncertainty. In extract 6 Mrs Roberts’ repetition of: “I don’t know” (lines 3, 6) when considering whether the anxiety and stress she experienced during her pregnancy were to account for: “the way Ian is” (line 6-7) mirrors extract 4 in this regard. Finally, consider Mrs Henderson’s: “*something* to do with attachment theory” (extract 4, line 10, emphasis added); Mrs Wilson’s: “*something* wrong” (line 2, emphasis added) and “it was *something* we were doing wrong” (extract 5, line 6, emphasis added); and Mrs Roberts: “maybe had *somethin*’ to do with the way Ian is” (extract 6, lines 6-7, emphasis added). The notion of “something” in these extracts, it is argued, works to convey the contribution of these environmental explanations in a more complex and multi-factorial causal pathway. These appear here, however, as vague, unspecified, difficult to quantify or articulate in their contribution – resting on “something to do with”. This appears in contrast to the more straightforward genetic explanations outlined above which appeared as: “it’s come from the man’s side a’ the genes” (extract 1, line 9); “I’m told it’s through me” (extract 2, line 2) and “so

that's where it's all come from" (extract 3, line 4). Thus what is noticeable here is the indirect formulation for the Environmental as "something to do with" versus the more straightforward and direct Biological repertoire which appears as "that's where it's all comes from".

In summary, different constructions of the child's difficulties were oriented to in extracts 4-6. An Environmental repertoire was invoked by reference to aspects of the child's local family environment. The discursive characteristics of this repertoire involved a complex explanation for the origins of the child's difficulties which implicated historical aspects of the *past parenting* influences (i.e. due to parental divorce, early separation anxiety, stress and anxiety during pregnancy). The implication therefore, is that there is something in the past parenting history which is to account for the child's later development of difficulties. In addition, this explanation was characterised by uncertainty and speculation and this worked to implicate a variety of parenting issues as possible problematic areas (i.e. in extract 4 it is unclear if the parental divorce is to account for the difficulties or if it is the early separation anxiety). Thus, unlike in the Biological repertoire the child's difficulties are not able to be accounted for due to external influences (such as the child's biological constitution) but are rather due to internal influences implicating parenting.

Subject Positions for Parents

The Biological and Environmental repertoires were elucidated above as contradictory repertoires. They also have very different implications for parental subject positions or identity as a parent which will now be explored. Table 1 below represents a graphic summary of the Biological repertoire and the Environmental repertoire as they were displayed in the previous data extracts. The purpose of this table should be seen as an illustrative working of the two repertoires, rather than exhaustive, for considering parent subject positions.

TABLE 1: PARENTAL ACCOUNTS FOR CHILDREN'S DIFFICULTIES

Repertoire	Context for the Child's Difficulties	Parental Subject Position available
Biological repertoire • **medical context**	***1. Genetic origins as an objective 'it'*** it's obviously come from my husband's genes (P5) Liam has it in his genes (P4) that's where it's all come from (P8) the likes a' generic (P8)	***2. Passive observer/ external*** we seen the signs (P5) so that's why Liam has it in his genes (P4) it's just the same traits (P8)
Environmental repertoire • **family context**	***1. Parenting origins as subjective 'I'/ 'we'*** my husband and I split up (P9) something to do with attachment (P9) because we split up (P7) I was really anxious (P2)	***2. Active causal agent/ internal*** social environment (P9) split (P9, P7) attachment (P9) you were doing something wrong (P7) your fault (P7) because of all the anxiety and stress (P2)

Table 1 depicts illustrations from the data for each of the repertoires. The origins and context of the difficulties are summarised together with the associated implications for parents' subject positioning. Reference to participant interview numbers is provided in parenthesis. From the table, it is clearly apparent that the child's difficulties in the Biological repertoire are characterised by an externalised location or 'it', involving the child's genetic constitution. In this way, the parent is positioned as someone that is external or objective to the child's difficulties as an inevitable genetic predisposition. In the Environmental repertoire by contrast, the child's difficulties are constructed in terms which implicate past parenting issues and which are recognised as central in a child's healthy environment. As such, they can be invoked to account for later difficulties that the child exhibits, employing a developmental paradigm. Reference to the self is evident (i.e. "I", "you", "my" or "we") which serves to implicate the parent as an active causal agent in the child's difficulty.

Summary

It was argued in the previous section that parental talk that accounted for the past origins of their child's difficulties deployed two discernible yet opposing interpretive repertoires. A Biological repertoire accounted for ADHD as a genetic condition. This genetic explanation was characterised by an orientation to medical authority and to past family history in order to give support for such biological explanations. This explanation occurred then within a medical context for the difficulties. In the Environmental repertoire, by contrast, a variety of environmental influences were able to be offered to account for the difficulties. These explanations drew from child developmental theories and were characterised as implicating a range of parenting influences as central. In these versions, it was the family context that was privileged over biological aspects and they appeared more complex, indirect and speculative. There were different subject positions made available from the deployment of the different repertoires. These were illustrated through the table which highlighted that in the deployment of the Biological repertoire, parents' subject position was an external one in relation to the child's difficulty. The child's genetic constitution was held to be accountable for difficulties and subsequently the parents' subject position was one of passive observer. An Environmental repertoire, however, was distinctly different because here the child's difficulties could be seen to implicate parenting influences. This meant that the subject position made available by this explanation was as an internal causal agent in relation to such difficulties, whereby parents' invoked themselves into these causal frameworks.

Parental accountability as an ideological dilemma

In light of the above analysis, if parents have available and at their disposal both a Biological and an Environmental repertoire as a cultural resource in talk about the origins of their child's difficulties, then it is evident that a potential dilemma exists for them in relation to negotiating their own causal role in the problem. Parents could clearly not be implicated in the child's ADHD in the Biological repertoire (except insofar as the transmission of genetic material as in extract 2, which could hardly be considered under parental volitional control in contemporary society). However a very different picture emerged with the Environmental repertoire in which parents could be implicated in a variety of different ways in relation to their past parenting behaviour (i.e. such as getting divorced, allowing early separation with the child,

being stressed during pregnancy). Drawing on such competing ideologies as ADHD genetic explanations and child developmental theories, is contradictory and qualitatively different for parental accountability. Thus the issue of negotiating parental responsibility and agency in the child's ADHD is central in this ideological dilemma.

Previous discursive research in the area of parenting and also in controversial illnesses may be illuminating here. For example, Baruch (1981) examined parental accounts of their child's congenital heart disease or cleft palate and noted the similarities of the accounts with other accounts from parents of children with a very different condition, that of cystic fibrosis (Burton, 1975; cited in Silverman, 2000). Baruch focused on the narratives as local accomplishments and drew from insights by Harvey Sack's (1974) membership categorisation which emphasised studying categories (such as parent, child etc.) along with their associated activities and how they were important. The work highlighted that parent and child relationships featured prominently in the study which was in keeping with previous studies which had emphasised the importance of parental responsibilities for their children (e.g. Voysey, 1975; cited in Silverman, 2000). So parental responsibility featured prominently in the illness accounts for their children from a range of conditions. Of particular relevance here, the analysis also showed how parents constructed narratives of an 'atrocity story' which was an effective means of demonstrating and attending to parental moral responsibility and adequacy in these narratives of the parenting. That parental narratives were found to be organised in order to attend to morality issues and issues of adequate parenting, may be a similar feature here. Further, in the area of the controversial illness of ME/Chronic fatigue, for example, Horton-Salway (2001) showed how participants oriented towards providing accounts of their own personal accountability and agency in that contested illness. Participants, to attend to the controversial status of that illness, talked-up their identities in order to give credence to physical accounts for the illness rather than psychological ones. In a similar vein, evidence from the previous section which indicated the opposing repertoires suggests that parents of children with ADHD may be similarly attentive to the controversial status of this disorder and have to manage biological and environmental explanations for that condition. In so doing, they have to attend to and account for their own moral responsibility for the condition which was an ambiguous one depending on the repertoire employed. Talk about a diagnosis of ADHD, where the child's difficulties are officially recognised as ADHD,

may be significant because a diagnosis of ADHD may represent an official medical confirmation and legitimating of the difficulties as an objective, external condition. The availability of the two opposing repertoires as demonstrated in the above and the ambiguous positioning of parents, means therefore that talk about diagnosis may be problematic and important in terms of the ideological dilemma it represents. Here it should be noted that diagnosis of ADHD is treated as a discursive event, deployed in interaction with the interviewer rather than an actual event. The following two lengthier extracts are presented for further analysis in which the interviewer asks a mother and joint parents about a diagnosis of ADHD.

Extract 7

Parent Interview 1: Mrs Morrison of Adam

I: so what does it mean then having this ADHD diagnosis then, for these parents
P: well that explains why he's a wee shit (laughs) I don't know I can't really answer for other parents particularly (I: yes) perhaps it's reassuring for some that it's not them because you don't have to beat yourself up as a parent
I: and is that an issue for parents
P: I think yes, talking to other parents who have children who are not not following the standard path (I: mhm) you think well what have I done wrong, what could I do better and that's always the first thing and the last thing you'd say to yourself or why did I, it must me
I: was that an issue for you
P: (.) I've a daughter who's two years younger (I: mhm)
P: so she's always been very reassuring for *me* (laugh) (I: laughs) that it's not me (laughs), but yes you know (I: mhm) and people with the best of intentions when he was little and that= (I: =yes) would say things like 'oh well we read um stories every night, have you tried' – '<u>of course I've fucking tried them</u>', in my head (laughs) (I: laughs) 'yes uh huh, oh well we find singing songs together very helpful', '<u>yes of course I've bloody tried them</u>' (laughs)
I: (laughs) (so) well-intentioned but misguided
P: yeah yes well-intentioned people trying to sort of be helpful (.) can sometimes make it worse (I: yes=) = but you do blame yourself, I *have* tried this I *have* done this but where did I go wrong what have I done wrong (I: mhm) so yes having the diagnosis is is made it takes you off the hook a little bit and can take some pressure off

Extract 8

Parent Interview 6: Mr and Mrs Johnston of Jessica

I: […] **was it easy for you to get an ADHD diagnosis once you went to [the psychologist]**
F: yeah we paid privately cos we couldn't wait any longer and she er
M: =but I mean that was ()
F: she diagnosed Jessica with ADHD and er
M: ()
F: it sort a (.) put things into place (.) us thinking we've got a really (stupid child) and the fact that we *don't* it's because she has ADHD (I: uh huh) so really (.) changed our point of view of looking at her (.) (I: right) as in (.) she's not a problem child she's a child with a problem (I: right) so you know
M: it's nice to have a diagnosis ()
F: it's not nice to put labels on things but it does put things into place and then you can=
M: =deal with it
F: =cope or deal with it and then start the ball rolling with how to deal with it rather than just ()
M: cos I think as a parent (.) we (.) (it's very) you know they've all been brought up the same (I: mhm) um (.) no kind of favourites or anything else (.) and there is this (.) devil (laughs) um
F: ()
M: and you're thinking you know where have we gone wrong (I: yes) you know she's been treated (.) and been reprimanded and (.) you know exactly the same as the others (.) but there she is (.) with a pair of horns and a tail
F: mhm
M: and and you do you think what have we done wrong this time
I: so you blame yourself
F: you see we we're quite old-fashioned even though we're just in our forties we're quite old-fashioned in the way we were brought up (I: mhm) we still think them values count today as well (.) […] and=
M: =we believe in kind of morals
F: =manners and morals and
M: yeah
F: and you know being (.) quite well brought up
M: yes
F: and we try to keep to our (.) I know a lot of parents today don't do that (.) but we do (.) and um (.) it's like if they get in to trouble (.) I've I've warned them if you get do something that's wrong I'll be the first person to march you up to the police station (.) they know that (I: yes) because we don't put up with that sort of thing ()
M:= a lot of parents wouldn't do that they'd be saying to the police 'oh' (I: laughs)
F: yeah
M: so I mean but that's how we were brought up and that's=
F: =that's the sort of how we trying to be with them (.) some people think we're too strict (.) when they tell their friends what we do (.) 'oh they're really strict' cos they don't watch TV during the week (.) because they've got so many activities at night (.) and homework and um (.) you know they only watch it at the weekends (I: yes) and (.) but we do a lot of stuff with them (.) cos they do […] (list of activities omitted) (I: oh right) so (.) we do try and get them as busy as possible but we're quite strict

Doing the 'Good parent'

It could be said that - on surface reading at least - it is apparent that the medical act of diagnosis (as mentioned above this is treated as a discursive act) is implicitly responsible for allowing the Biological repertoire to achieve dominance over the Environmental repertoire and over its associated unclear aetiological implications for parents. If ADHD is recognised by medical professionals for the child, then clearly there are no past parenting issues implicated with the parenting to be resolved. It has been argued in the literature that a diagnosis allows parents to feel less blamed for their child's difficulties as a construction of a medical condition. There is certainly this sense in the data extracts if we take them at face value: that parents do feel less blamed because there is a medical explanation for the difficulties. However this data will be examined further for the resolution of the ideological dilemma as it is maintained that parental discursive talk is more complex than this initial reading.

In the above extracts the dilemma between the Biological repertoire and the Environmental repertoire is clearly discernable. In the first instance, we see parental talk orienting to an external problem as rooted within the child; as a biological and genuine condition. In extract 7, Mrs Morrison refers to a child with such difficulties generally as a: "wee shit" in line 3, and then more moderately as: "children who are not following the standard path" in lines 7-8. In extract 8 Mrs Johnston refers metaphorically to a: "devil" (line 19) and then extends this metaphor: "with a pair of horns and a tail" (line 23). This is also seen in Mr Johnston's: "us thinking we've got a really (stupid child) and the fact that we *don't* it's because she has ADHD" (lines 7-8). His reformulation of "she's not a problem child she's a child with a problem" (lines 9-10) picks up an earlier co-construction (not produced here) where the Johnston's had negotiated Mr Johnston's use of: "problem child" in favour of "difficulties". Mrs Morrison's account of a: "wee shit" (line 3) may be heard as ironic in the first instance, because she does not refer to her own child in this way, but may be referring to a general consensus of such children. However, a "wee shit" (extract 7, line 3), "a devil" "with a pair of horns and a tail" (extract 8, lines 19; 23) as well as a "child with a problem" (extract 8, lines 9-10) is noticeable in these extracts as extreme and telling of a objective problem which is constructed as characteristic and applied to the child. This works to achieve authenticity for a real and biological condition where the difficulties are located within the child, which invokes a Biological repertoire here.

In the second instance we see clearly that parental talk is also, and at the same time, orienting to the membership category of parents. This is evidenced with: “talking to other parents” (extract 7, line 5); “you don’t beat yourself up as a parent” (extract 7, line 7) and: “cos I think as a parent” (extract 8, line 17). From this we see evidence that parents are talking and orienting to their position *as parents*. With the orientation to the category of parents, talk is thereby oriented towards the Environmental repertoire in which the problem with the child is construed as a problem that implicates and originates from within the parenting. This is seen in extract 7 when Mrs Morrison orients to the interviewer’s general question: “so what does it mean then having this ADHD diagnosis then for these parents” (line 1). Her response of: “perhaps it’s reassuring for some that it’s not them because you don’t have to beat yourself up as a parent” (lines 4-5) and: “you think well what have I done wrong, what could I do better and that’s always the first thing and the last thing you’d say to yourself or why did I, it must be me” (lines 8-10). This orientation succeeds in highlighting an internal subject position where parenting issues are at stake in the child’s difficulties. The repetition of “I” and “me” is further indication of the problem as temporarily owned by the speaker (as opposed to located within the child). Here the initial orientation to parenting issues is probed further by the interviewer (“is that an issue for parents” in line 6, and later in line 11: “was that an issue for you”). Thus Mrs Morrison’s later turn with: “but yes you know” (line 14) and later: “but you do blame yourself, I have tried this I have done this but where did I go wrong what have I done wrong” (lines 21-22). This turn is significant because Mrs Morrison’s account is hearable as originating from within her own parental experiences rather than parents in general. Once again the repetition of “I” and “wrong” locates the problem within the parent rather than the child. This is also seen in extract 8, line 21, with Mrs Johnston’s: ”and you’re thinking you know where have we gone wrong (I: yes) you know…” and a few lines later in line 25 with: “ you do you think what have we done wrong this time”. This works in a similar way to extract 7. However it is significant that this is oriented to by Mrs Johnston (as opposed to Mr Johnston, this is discussed below). Nevertheless in both extracts there is evidence that parents orient to the dilemma that the child’s difficulties could be caused by problems with the parenting; an internal causal subject position as opposed to an external subject position is being negotiated. It’s clear that in this way, parental talk can be seen to orient to the notion of the self and identity as a parent which is quite unlike talk characteristic of the Biological repertoire.

Allied and tied to parental talk about diagnosis is the further discursive feature of what may be called doing '*Good parenting*' talk. In the two extracts presented there are a number of discursive features at work for this purpose. When the interviewer asks Mrs Morrison in extract 7, line 11: "was that [blame] an issue for you", her next turn is significant with: "I've a daughter who's two years younger (I: mhm) so she's always been very reassuring for *me* (laugh) (I: laugh) that it's not me" (line 12-13). This pattern is evident in extract 8 with Mrs Johnston's: "cos I think as a parent (.) we (.) (it's very) you know they've all been brought up the same" (lines 17-18). Here when the issue of parental responsibility appears in these extracts, both Mrs Morrison and Mrs Johnston orient to the presence of their other, supposedly 'normal' children. The availability of the turn to other children is utilised discursively and is significant because presumably these children would have had the same environmental upbringing as the ADHD child, thus making parental influences for difficulties less likely. Thus the implication is that it can't be the parenting that is at fault, it must be something else, such as a biological constitution. This works to demonstrate that the parents are 'good parents' and can not be accused of doing anything wrong.

There is another discursive feature that is at work which is tied to the 'good parenting' work in these extracts and which is hearable as a turn to present parenting practices. After the turn which introduces the presence of a 'normal' daughter and an admission of feelings of blame ("but yes you know", line 14), Mrs Morrison's next turn can also be regarded as significant with the orienting to a narration of well-intentioned advice by those around her: " and people with the best of intentions when he was little and that = (I:=yes) would say things like 'oh well we read um stories every night, have you tried' – '<u>of course I've fucking tried them</u>' in my head (laughs) (I: laughs) 'yes uh huh oh well we find signing songs together very helpful', '<u>yes of course I've bloody tried them'</u> (laughs)…" (lines 14-18). Here the juxtaposition of the giving of simple parenting advice techniques by those around her (reading stories and singing songs) with Mrs Morrison's extreme reaction to them (seen in her inner, loud talk of: "'<u>of course I've fucking tried them</u>', and '<u>yes of course I've bloody tried them</u>'") is significant. This juxtaposition works to highlight the severity of the problem with the child, with the ineffective and rather obvious parenting tips. It works to highlight the account as something that is beyond mere simple parental efforts and the implication is that there is something much more severe and profoundly wrong, which works to implicate the Biological repertoire. The

juxtaposition also works in another way: it achieves a sense of good parenting in this extract with the repetition of: "'of course I've fucking tried them'" (line 16), "'yes of course of bloody tried them'" (lines 17-18) and: "I have tried this I have done that…" line 21). The use of "of course" works to highlight the parent as a rational and reasonable person who has exhausted all the available means. It also refers and invokes a culturally shared world with the interviewer, in which such common parental techniques are regular. The dismissal of the parenting tips works to further achieve the difficulties as enduring because, clearly in this account, such strategies are obvious and simplistic and one of the first things a 'good parent' would have tried. Thus Mrs Morrison's: "so yes having the diagnosis is is made it takes you off the hook a little bit and can take some pressure off" (lines 22-23) is not taken at face value in this analysis. Instead talk is treated here as an active, local, discursive accomplishment of 'good parenting' talk which is achieved largely through orientation to active parental efforts as seen in the repetition and reference to: "I've tried" (lines 16; 17-18; 21). Active parental efforts then are being invoked here, as tied to the character of a 'good parent', and in contrast to the opposition of the child with severe difficulties.

This is similar in extract 8 although the details are different. After Mrs Johnston's orientation to the presence of other healthy, non-ADHD children and orientation to notions of current parenting at stake, the interviewer's probe of: "so you blame yourself" (line 26) is taken up by Mr Johnston. While Mrs Johnston could be seen clearly in the lines before to be orienting to issues of parenting, Mr Johnston takes up a turn which sees him reconstructing issues of parental responsibility. Instead of responding to this as a question (i.e. through 'yes we do' or 'no we don't'), Mr Johnston treats this as an opportunity to give an account and further orientations to their identity as parents. He too invokes the presence of other children (non-ADHD) although these lines were omitted from this extract in order to protect anonymity. His account can be seen as a construction of the joint identities of the parents (which previously Mrs Johnston had oriented to as problematic). His: "we're quite old-fashioned…" (line 27) and: "we still think them values count today as well…" (lines 28-29) is the beginning of a joint piece of construction which Mrs Johnston takes up and contributes to (i.e.: "we believe in kind of morals", line 30). This joint construction works to establish the parental identity as one that employs good old-fashioned values and can be seen to be doing the same type of work as the earlier extract in producing an account of 'good parenting'. This is in further

evidence later on in the extract when Mr Johnston produces an explicit contrast with other parents: “I know a lot of parents today don’t do that (.) but we do” (lines 35-36). Here Mr Johnston creates a distinction between other parents and themselves: other parents who presumably don’t believe in bringing up their children well (see previous turn) in comparison to the Johnston’s efforts in bringing up their children well (and having morals and manners etc.). This distinction relies on a contrast between faulty and lax parents versus the Johnston’s as ‘good parents’. This is further accomplished with the example furnished by Mr Johnston: “it’s like if they get in to trouble (.) I’ve warned them if you get do something that’s wrong I’ll be the first person to march you up to the police station (.) they know that (I: yes) because we don’t put up with that sort of thing ()…” (lines 36-38). In this account we see the distinction between ‘good’ and ‘bad’ parents again. While ‘bad’ parents may accept their children doing something that’s wrong, Mr Johnston in contrast has warned his own children that he would turn them into the police himself if they did something wrong. His concern for justice and non-acceptance of bad behaviour is hearable as marking him as a ‘good father’ that is concerned with discipline. Mrs Johnston can be seen to be jointly producing this account with her overlapping turn of: “=a lot of parents wouldn’t do that they’d be saying to the police ‘oh’” (line 39). Here we see the construction of other, lax parents not owning up to their children’s behaviour with the police while the Johnston’s, in contrast, are actively law-abiding (and further law-enacting citizens) even if it means turning in their own children to the police. Mr Johnston’s overlap with Mrs Johnston’s turn of parental identity: “=that’s the sort of how we (are) trying to be with them (.) some people think we’re too strict…” (lines 42-43) is also highly significant. Notice the repetition of “strict” in this turn (“some people think we’re too strict” (line 42-43), direct reporting of: “’oh they’re really strict’” (line 43) and later: “…but we’re quite strict” (line 47). Here the construction of “strict” moves from an indirect reporting of: “some people think…” to the more direct reporting of: “oh they’re really…”, to the eventual labelling of themselves as: “we’re quite…”. In other words it’s not just that the Johnston’s see themselves as strict, but that this comes from outside sources and hence works to achieve a sense of consensus and corroboration for the account (in discursive psychological terms, e.g. Potter, 1996). This is significant because in an account of parenting a child with ADHD in a research interview, where issues of parental accountability and responsibility require resolution, one way of attending to this is by an orientation to the extreme and opposite position of a very “strict” parent in an effort to do ‘good

parenting' work and thereby achieve credibility for the child's condition as biologically based. In lay and media theories that circulate about 'bad parents' or lax parenting causing a child's problem behaviour, one way around that then is to orient to being "strict" in an effort to accomplish 'good parenting'.

Summary of the 'Good parent'

Extracts 7 and 8 were used as examples in the above analysis to illustrate the discursive work that was involved in dealing with the ideological dilemma of parental accountability for the child's difficulties. These difficulties arose due to the availability of competing interpretive repertoires: the Biological repertoire and the Environmental repertoire which draw from competing paradigms as ADHD medical constructions or child development theories. Similar patterns were observed in these extracts and which were present in the larger corpus, to demonstrate how such an ideological dilemmas was resolved. The overriding pattern in the data was that parental talk was oriented to moral issues and the character and actions of parents as adequate or 'good parents'. This required a great amount of discursive work in the extracts, as elaborated above. In the controversial condition of ADHD, the above extracts highlighted that such work that oriented to 'good parenting' was complex and extensive.

In both extracts we saw a distinction created between the child and their extreme behaviour on the one hand, versus the 'good parent'. Both Mrs Morrison and Mrs Johnston oriented both to notions of the child as the problem (i.e. the "wee shit" and the "devil") and yet both oriented to notions of their identity as parents. In attempting to overcome this dilemma, it was argued that parents were engaged in what was called 'good parenting' discursive work. In the first instance both Mrs Morrison and Mrs Johnston oriented to their status as 'good mothers' by the presence of other, non-ADHD children. In the second instance, both Mrs Morrison and Mr and Mrs Johnston oriented to their active efforts and status as 'good parents'. For Mrs Morrison this is achieved when she discredits simplistic and obvious childcare tips as efforts that she would undoubtedly do anyway. For the Johnston's this is a more complex account in which they worked to accomplish their identity as "strict" parents and in this way avoid being implicated in causing their child's problem behaviour. While Mrs Morrison relied on an identity consistent with a reasonable and rational parent responding to extreme behaviour, the Johnston's

relied on a contrast that the account set up between their parenting versus other lax parenting. In both instances the effect was the same: to position the parenting as external from the difficulties and thus give emphasis to the child's difficulties. Further, in both extracts the rhetorical device of *trying/tried* is significant as it is tied to the active 'good parenting' efforts. What is further noticeable in these extracts is a construction of extremity in the parenting: Mrs Morrison's harsh language and extreme reaction to simple child advice tips from others and the Johnston's - not just as disciplined parents - but as "strict". As was argued above, this worked to counter the notion that parenting was lax or somehow at stake in the child's behaviour. The effect is to almost present a heroic picture of the parents by their efforts (i.e. having exhausted all the commonly known childcare tips; and by the image of marching their children to the police if they did something wrong). Finally, what was also significant in these extracts was that a diagnosis as a discursive event was allied and tied to the 'good parenting' work. It did not exist as a means of resolving the ideological dilemma but depended on further discursive constructions of 'good parenting'. Thus what was significant was that greater discursive work was associated with diagnosis talk in order for parents to attend to their status as morally adequate or good parents for a controversial illness. Further, while the Environmental repertoire was associated with talk about past parenting influences in the child's difficulties in the previous section, here, talk about diagnosis was tied largely to *present parenting practices* in order to constitute 'good parenting'.

Parental accounts for competing views by others: the school and the family

In the controversial condition of ADHD, within parental accounts, there were competing explanations for the child's difficulties readily available in relation to others' views. How parental talk was able to attend to such competing views is a feature for further analysis. It is expected that parental accounts would be robust in order to attend to alternative explanations for the child's difficulties (e.g. Edwards and Potter, 1992). The availability of the two competing interpretive repertoires that were invoked in parental accounts was previously outlined above. The previous analysis highlighted how parental talk was organised in order to maintain biological explanations about the children's difficulties through reference to 'good parenting' discursive work. However talk about the school and wider family also highlighted the availability of competing explanations for the child's difficulties according to parenting explanations as rooted in the Environmental repertoire. This section

considers how parents were able to maintain constructions about the child's difficulties as ADHD in the face of competing and distinctly opposing views that appeared about the child's difficulties. Thus the analysis is concerned with parental orientations to others, as holding divergent views, in order to examine how such ADHD constructions were managed discursively. Similar discursive features were observed across a range of areas where disagreements were invoked. The following three extracts are presented in order to represent examples of extracts of competing views by schools as well as family members and friends. How parents managed accountability for such competing views to their own views is examined. The following extracts are presented for analysis.

Competing views by schools

Extract 9

Parent Interview 2: Mrs Roberts of Ian

I: […]
P: Dr (.) Dr M sent away for a report (.) he's actually sent away for two (I: ok) sent for a report to the teacher first (.) no reply sent again (.) no reply (.) he says 'right we'll go one step further we'll go to the head teacher' (I: mhm) he got a reply saying' that 'Ian's a wonderful little child' em 'he's fine and he does everythin' that he should and there's nothin' wrong with him' (.) and I went 'fine ok thank you very much' (I: mhm) and then (.) the next time I went em (.) I got a report card (I: mhm) and it said and tha' (.) 'Ian would be ok if he just sat down and done (.) done what he was told but he's no he's not (I: mhm) but he's not not doin' what he's told' (.) (I: mhm) and I thought 'how are you how dare you play with my child's health (and my health)' so I phoned to speak to Mrs Smith […] [later] cos it's like they're not recognisin' it *yeah* it might be similar to normal children and that's a pattern (.) but you have to look at it that he *has* got a problem cos he wouldnae be on medication (.) he wouldnae be seeing a paediatrician (.) the paediatrician wouldnae entertain him (.) if he thought there wasnae a problem

Extract 10

Parent Interview 6: Mr and Mrs Johnston of Jessica

I: **[…] and what is your relationship like with the school**
F: it's fine
M: yeah I would say ok (F: mhm) (I: mhm) I mean they know I'm pretty straight talking […] I actually said to him that I don't think he's (.) what was it when the educational psychologist (.) (F: mhm) when we had a meeting and I actually said you know I really don't think he's (.) he can (.) he *could* do
F: better

M: better (.) (F: mhm) with his strategies (.) […]
F: cos she was coming home in tears at times (I: right) 'oh he keeps telling me off' and all this sort of thing (.) but when we found out why you know (.) it's silly things like she was tiddling with her pencil too much (I: yes) which is=
M: =but that's what they do
F: which is what they do (.) and you know we'd go up to him and say look she's twiddling because it's her ADHD
M: or a rubber or stuff
F: so we got the child psychologist up there and I went to the first meeting (I: yeah) and she turned to him turned round to him and said 'you can't keep telling her off (.) this is part of the ADHD' but I think [it] just went over his head (I right) because he *has* the (.) what was it these schools have to deal with these problems
M: the guidelines
F: the guidelines yeah (I: uh huh)
M: but I don't think (.) I haven't seen the guidelines as such
F: no you can ask for them but (.) we don't think he uses them (I: right) you know and I mean I've been there […] and they did nothing but shout at the kids

Competing views by family

Extract 11

Parent Interview 7: Mrs Wilson of Paul

I: […] **How about other people around you (.) how did they react**
P: um (.) my Mum and Dad still to this day think there's nothing wrong with Paul (.) I don't know if you remember when you were a kid but I'm sure when you went to go and visit somebody or stay with somebody you always behaved better than you would for your parents (I: yeah) in fact your parents could say you've been a total nightmare this week and you'd go and away and they'd come back and they'd say 'oh she's been fine' (I don't have a problem kind of thing) (I: mhm) but that's what it's like with Paul […relates an example of a holiday with parents] I was staying somewhere else um cos we don't get on get on [see] eye to eye when I've got Paul because we've got different views […] so they feel it's my parenting skills that are at fault not that's he got ADHD (.) […] [Dr R] says that 'Paul you've got ADHD' so he thinks he's got ADHD and the people at the nursery whose dealt with kids with this problem think he's got ADHD then surely he must have ADHD you know all these people can't be wrong (I: mhm) and my Mum and Dad have never dealt with it before (I: mhm) they're not aware of what ADHD is (I: yes) or even understand the full concept of the matter (.) so ok they've had five kids but they've had five kids that (.) haven't had ADHD

In the lengthier extracts of 9-11 there is a lot that is happening. The analysis is concerned, however, only with common features across the extracts in relation to parental accounts of competing views. It is clear that these extracts are accounts oriented towards stories of opposition. Here there is the simultaneous orientation towards parental views in stark opposition to the views as held by others (i.e. the school, friends and extended family). Where this simultaneous orientation occurs then, provides a fertile arena for the exploration of how parents account for competing versions. In these extracts it is the interviewer that introduces this as a topic for consideration, as in: "what is your relationship like with the school" in extract 10; "how about other people around you (.) how did they react" in extract 11. Opposing accounts are hearable in these extracts in various ways. In extract 9, lines 5-6, Mrs Roberts invokes the schools' account as: "'Ian's a wonderful little child' em 'he's fine and he does everythin' that he should and there's nothin' wrong with him'. This appears in stark contrast to a biological condition (which in the interview narrative has been hearable). In extract 11, line 2, Mrs Wilson invokes her own parents' accounts as: "my Mum and Dad still to this day think there's nothing wrong with Paul". These accounts by the school and the grandparents are invoked in these instances as problematic. It was argued earlier that parents drew from contradictory Biological and Environmental repertoires to account for their child's difficulties. It was through 'good parenting' work that parents were able to achieve biological explanations for the child's difficulties. Thus the biological repertoire featured in these accounts as the dominant repertoire. In contrast to the discursive work in parental accounts then, it is clear that orientations to competing versions for the child's difficulties can be seen as a threat to such formulations. These accounts are hearable as environmental explanations which invoke the parenting.

In relation to the above, and in keeping with a dominant Biological repertoire to account for the child's difficulties as ADHD, in the extracts 9-11 it is clear that parental talk shares a number of features. Firstly parental accounts are aligned with a range of experts. This alliance between the parent and the expert is clearly demonstrated here. Thus in extract 9, Mrs Roberts is aligned with "Dr M" the paediatrician in order to obtain a report from the school. In extract 10, Mr and Mrs Johnston appeal to the educational psychologist to inform the teacher about the difficulties. Similarly in extract 11, Mrs Wilson reverts and aligns her talk with reference to the child paediatrician and educational experts (at the nursery). In the alliance with the experts, parental talk in the second instance, achieves a division

with the other *non-experts* which invokes the school in extracts 9 and 10, and the grandparents in extract 11. Finally and tied to this, along with the alliance to the expert then, parental talk also invokes expert knowledge and talk about ADHD in order to further demonstrate expertise. So in extract 9, line 11-12, Mrs Roberts states: “yeah it might be similar to normal children and that’s a pattern”. The use of “pattern” works to achieve specialist ADHD knowledge about how such children would appear. Similarly, in extract 10, line 12, the Johnston’s refer to their own expertise on ADHD with the Johnston’s unanimous: ”but that’s what they do” as constituting obvious signs of ADHD; Mr Johnston’s: “you know we’d go up to him and say look she’s fiddling because it’s her ADHD” (lines 13-14) also achieves specialist ADHD knowledge here.

Against a medical view, tied to parental use of the Biological repertoire and which utilises expert knowledge, a contrast is created with the non-expert school and family. What is significant is that in these accounts for competing views held by schools and families, we see the overarching pattern exhibited of attributing these views as due to personal failings rather than due to expert knowledge. In extracts 9-11 then, we see ignorance, bias and negligence to account for competing views. In extract 9, lines 2-4, the school is presented as negligent in their lack of response to the paediatrician’s request for a report as seen in the repetition of: “sent for a report to the teacher first (.) no reply sent again (.) no reply he says right we’ll go one step further…”. Next the school present a contradictory report, as seen in the ironic: “thank you very much’ in line 6. This leads to the more severe accusation seen in: “how dare you how dare you play with my child’s health” in line 10. Finally in line 11, the school are considered as: “they’re not recognisin’ it”. Thus this extract paints a picture of the school as negligent, ignorant and subject to bias and distortion which impact negatively on the child’s health. A similar account is worked up in extract 10 where the Johnston’s present the teacher firstly as petty as seen in: “’oh he keeps telling me off and all this sort of thing (.) but when we found out why you know (.) it’s silly things like she was tiddling with her pencil too much” (lines 10-11). The inconsequential act of “tiddling” with a pencil is constituted as a failing in the teacher for being petty, and victimising the child. Further work constitutes the teacher as ignorant. This is achieved by the orientation to the common and shared knowledge base about ADHD children seen in the repetition of:” but that’s what they do” by Mrs Johnston (line 12) and: “which is what they do” by Mr Johnston (line 13). This apparently common knowledge about ADHD is distinct in its absence from the

teacher's knowledge. The further orientation in lines 16-8 to parental active efforts seen in: "so we got the child psychologist up there and I I went to the first meeting (I: yeah) and she turned to him turned round to him and said 'you can't keep telling her off (.) this is part of the ADHD' but I think it just went over his head". Here knowledge dissemination about ADHD is actively worked up by the orientation to the child psychologist's advice to the teacher. The use of: "but I think it just went over his head" further works to constitute the teacher as ignorant and incapable of comprehending medical concepts.

In Extract 11, a similar construction of ignorance is achieved by Mrs Wilson with regards to her parents. Like the other extracts above, the grandparents and their views are seen in contrast to that of the experts ("Dr P" and the "people at the nursery whose dealt with kids with this problem" in lines 13-14).The: "…then surely he must have ADHD all these people can't be wrong…" (lines 13-14), echoes extract 9's (line 13-15) earlier: "…that he has got a problem cos he wouldnae be on medication (.) he wouldnae be seeing a paediatrician (.) the paediatrician wouldnae entertain him (.) if he thought there wasnae a problem". This line of reasoning depends on the expert construction – if a range of medical and child experts think the child has a problem, then surely the child does have a problem. Extract 11 similarly constructs the grandparents as ignorant in relation to ADHD knowledge: " my Mum and Dad have never dealt with it before (I: mhm) they're not aware of what ADHD is (I: yes) or even understand the full concept of the matter" (lines 14-16). This is seen further in: "so ok they've had five kids but they've had five kids that (.) haven't had ADHD" (lines 16-17). Clearly the medical status of the condition is conceived as too specialist or technical for these lay, non-expert grandparents.

In sum, it clearly requires complex discursive work in order to accomplish the Biological repertoire for the child's difficulties in the face of such competing constructions by others such as schools and grandparents. Schools and grandparents, by implication, are knowledgeable and experienced about children's general behaviour. Thus parental accounts attend to this by using the expert and specialist knowledge about ADHD in order to achieve a medical explanation for the child's difficulties. The above extracts had a range of similar features in order to do this: the alignment with other experts such as paediatricians and educational experts; and the use of specialist ADHD knowledge. Thus opposing views (by the school and the grandparents) can be constituted in terms of non-expertise and due to personal failings like bias and ignorance in contrast to medical expertise. There

are striking parallels with this aspect of the data and other research in discourse analysis which will be considered below.

The error-accounting of others' views as due to dispositional factors and the presentation of one's own views as due to the 'facts' as they stand is a well-known feature from a range of discursive studies as highlighted by Edwards and Potter (1995). The classic study by Gilbert and Mulkay (1984) of the analysis of scientists' discourse is a well known example of this and will be revisited here briefly. The analysis highlighted how scientists' were able to account for their own theories using an empiricist repertoire which oriented to scientific knowledge and objectivity in formal contexts. They were simultaneously able to account for competing theories using the contingent repertoire in informal contexts whereby subjectivity and personal bias plagued accounts for others' theories. Clearly the parallel with the work here is that parents, similarly, were able to account for their own explanations using the Biological repertoire (as highlighted in the earlier analysis) to offer genetic explanations. This was conducive to the medical explanations and tied to expert knowledge. In contrast, other explanations (largely employing the Environmental repertoire) offered by schools and family were attributable to personal failings such as due to ignorance about ADHD and bias. Thus what is noteworthy in these lay parental accounts is that they too relied on an orientation to Gilbert and Mulkay's (1984) empiricist accounting device in the local deployment of the Biological repertoire. Thus parents were able to achieve credence for their own accounts of ADHD through similar means of invoking ADHD experts. Finally, in Gilbert and Mulkay's (1984) study, a rhetorical device called the 'Truth will out' device enabled scientists' discourse to overcome the dilemmas within such accounts. According to this device, through further scientific discovery and the passage of time, the 'truth' of the scientists' theories would be revealed and would serve to undermine and demonstrate the inaccuracies in rival theories. How such resolution of dilemmas occurred in parental talk will be explored further below.

'Cancer's everywhere': Getting ADHD 'out there'

Extract 12
Parent Interview 2: Mrs Roberts of Ian

1 **I: […]**

P: […] to be honest I didnae tell people that Ian's got ADHD I say Ian's got a behavioural problem (I: why is that) cos when people hear ADHD 'oh aye right'
I: oh so do you think that people don't (.) don't be=
P:= don't recognise it just feel that these kids need a real hit or belting but they havenae had a kid quite like tha' so could they say
I: so you don't think the name really means anything cos people don't believe it exists
P: don't na na it's like it's an alien (I: oh) you know I mean see years ago cancer was never a word (I: yes) and **nowadays cancer's everywhere and everyone's accepting it now but it's taken years** (I: yeah) but ADHD folks say 'aye right ken that's bairn's just being destructive he's just a little shit we don't want anything to do with 'im' (I: oh) and that's their attitude (.) shopkeepers an you're up against everybody (I: oh) the public (.) you know

Extract 13

Parent Interview 4: Mr McKay of Liam

I: […] and how do you feel how do you think ADHD's portrayed in the media or news
P: it isnae (I: isn't) nah (.) nah it's it's not (.) **I mean they've got charities for cancer etc left right and centre** (.) and yet ADHD (.) I can't even remember it being on the television (I: mhm) I tell you a lie (.) there *was* (.) there was a documentary […lines omitted as P relates the documentary]
[…] you mentioned that the head teacher in the beginning (.) I don't know if it's she didn't believe that Liam had ADHD or that it doesn't exist (.) how do you feel about people's belief like that
P: I feel that if it was publicised more (.) if folk understood that sometimes (.) hyperactive children aren't just bad children (I: mhm) they have got a slight illness () I think it er it wouldn't be so embarrassing (I: yeah) at shops or at school or whatever (I: right) if people were made more knowledgeable about ADHD (I: mhm) that's (but) **it's no it's no out there**

The above extracts, 12 and 13, are examples that demonstrate how parental accounts made use of a common rhetorical device in order to manage their own medical views for the child's difficulties as ADHD (use of the Biological repertoire) and account for contradictory views invoked by schools, families and the public at large (associated with reference to the Environmental repertoire). Central to the above extracts, it is argued, is the rhetorical device which is associated with being or getting knowledge about ADHD "out there" (extract 13, line 8). Knowledge dissemination through publicity is also oriented to earlier in this extract in line 4 of this extract. In extract 12, likewise, Mrs Roberts invokes a contrast with ADHD knowledge and cancer. According to this extract: "nowadays cancer's everywhere and everyone's accepting it now but it's taken years" (extract 12, line 9-10, highlighted) and this is seen as in contrast to ADHD which is: "like an alien" (extract 12, line 9). From the logic presented within these extracts then, the remedy is to

aspire to further advancement of ADHD knowledge in order to inform those that are ignorant. Similarly, in line 3-4 of extract 13, Mr McKay also invokes the cancer analogy with: “I mean they’ve got charities for cancer etc. left right and centre”. Here, as in extract 12, cancer has achieved an established and widespread acceptance in society. This is in contrast to ADHD. Like Gilbert and Mulkay’s (1984) ‘Truth will out’ device which scientist’s deployed in order to resolve the tensions between accounting for others’ views as contingent while holding an empiricist repertoire for their own theories, the parallel is that in these lay accounts, parents deployed a similar rhetorical device of ADHD knowledge getting ‘out there’ in order to inform public awareness and thus resolve their ‘faulty’ views about such children.

Summary

Parental talk attended to competing versions of the child’s difficulties through the use of expert knowledge about ADHD through which it was possible to construe the school/family as holding views from a biased or ignorant position. ADHD expertise and knowledge was clearly used in this way to maintain the Biological repertoire for the difficulties and which ultimately preserved the identity of the ‘good parent’ it entailed. Through the use of the analogy with cancer and getting ADHD knowledge ‘*out there’*, a similar orientation to enlightenment through knowledge was deployed. Like Gilbert and Mulkay’s (1984) ‘truth will out device’, a similar orientation to the progress of scientific knowledge was invoked where such ignorance would be superseded by the eventual recognition of the condition. This is reminiscent of the working of the empiricist accounting in the scientists’ discourse, although here it appears in the context of lay parents’ discourse about ADHD.

Having ‘options’ versus ‘being at wits end’: Accounts of the ‘good parent’ and Ritalin

Parental talk about medication is also significant for analysis, it is argued, because of the possible tension that such talk about a controversial medication may have for parental identity as a ‘good parent’. As highlighted in the literature review (chapter 3) there is very limited research which has considered parental accounts of medication such as Ritalin. Such focus is important because analysis of medication as treatment is considered relevant in a range of health areas to be important for

notions of ‘adherence’ with treatment protocols (e.g. Bussing et al, 2001). Harper (1999), for example, highlighted how analysis of medication has been a neglected area generally and indicated Yardley’s (1997) distinction between the mind and body as a means of relegating such areas to the physical. Parental talk about medication in ADHD is important because parents remain central in the treatment choices for their children. There was a range of talk in relation to medication by parents. The analysis here is concerned with an exploration of parental subject positioning in relation to the medication, and in considering the relation of this with the ‘good parent’ identity. In this analysis two distinct ways of positioning for parents were explored in relation to talk about medication which maintained the identity of the ‘good parent’. These are considered below.

‘Being at wits end’: Accounts of desperation

Extract 14

Parent Interview 3: Ms Buchanan of Sean

I: **How did you feel about that [medication]**
P: well (.) it was either you put up wie it or (.) the only other option was to hav` medication (I: mhm) so there’s no really (.) no other way out eh (I: yes) really

Extract 15

Parent Interview 8: Mr and Mrs McCormack of Gary

I**: How did you decide about that [mediation] (.) was it (.) at the time**
F: well we thought anything (.) please () (I: yes)
M: uh huh
F: just to try and to help him as well as us I suppose (I: uh huh)
M: we didnae we didnae we didnae want medication obviously but we were at our wits end we didnae know what to do

In the two short extract above it is clear that when the interviewer asks directly about the medication that a similar orientation has occurred, this was pattern in a number of accounts. In the above it is clear that a construction of desperation characterises these accounts in relation to the medication. For example, in extract 14, line 2-3, Ms Buchanan’s: “well (.) it was either you put up wie it or (.) the only other option was to have medication (I: mhm) so there’s no really (.) no other way out eh (I: yes) really”. In this account there is no choice and no alternative options available and thus

medication is heard as the *only* available solution. In extract 15, the desperation is heard in line 2 with Mr McCormack's: "well we thought anything (.) please…". In line 5-6 Mrs McCormack's: "we didnae we didnae we didnae want medication obviously but we were at our wits end we didnae know what to do" a similar construction of desperation is offered. In this turn there is evidence that Mrs McCormack is orienting to the stigma associated with medications like Ritalin seen in the repetition of: "we didnae we didnae we didnae want medication obviously". The use of "obviously" is heard as an indication of the 'good parent' status, it is argued. The reason that the parents "obviously" didn't want medication is taken here as an indication that no good parent would want to resort to medication for their child. (Ms Buchanan had similarly oriented to the stigma associated with medication later in the interview, not produced here). However, clearly "being at our wits end" and "we didnae know what to do" invoke the sheer desperation and lack of alternative resources available for the parents. Thus the medication in both these extracts can be heard as the *only* available solution. Against this, the positioning of the parent in relation to the medication is largely a passive one, as someone who reluctantly accepts such treatment in the face of outside, external influences relating to a lack of other treatment options.

Having 'options': Accounts of other options and resisting Ritalin

Extract 16

Parent Interview 4: Mr McKay of Liam

I: **so what is your relationship like with Dr Marks or with the doctors you deal with**
P: it's mainly Dr er Marks and I don't like her attitude (I: right) the last time my wife as down she more or less told *her* that she was putting Liam on them [medication]
I: she was putting Liam on them
P: aye well my wife said 'well we're not keen on them at all' she said 'well I'll give *you* leeway of three months or so (.) and when I heard that I was quite annoyed (I: yes) I won't let anybody talk to my wife like that for starters (I: yeah) and secondly (.) especially a professional doctor shouldn't be (.) she's there to advise you not to tell you (.) she was more or less telling her (I: right) and I think that was (.) my wife will tell you the exact same thing (.) she was quite disappointed in her (I: right I see) trying to *force* (I: yeah) these tablets on er my son basically our son (.) people some people with maybe less stre (.) willpower than my wife let's just say might have gave in and said 'well oh ok then' (I: yes) see my point a' it (I: yeah) which isn't right (I: yeah) they're manipulating a mothers mind *I think* (I: yes) in doing that so disappointing (I: right) […] aye she does know she does know that we're not wanting

em Liam on well we don't want Liam on (.) Ritalin (I: yes) er I'll only try (.) natural medicine and we've told her that (I: yes)

Extract 17

Parent Interview 1: Mrs Morrison of Adam

[The parent had been discussing prejudice in ADHD and was asked by the interviewer to elaborate on this topic]

P: […] I've been to a few parent support groups and what not and talked to other people and all the rest of it (.) I think (.) I don't know whether it's (.) in order to (.) it's a *battle* to get resourcing for children (I: mhm) there are finite amounts of resources (I: yes) so the one who shouts the loudest gets (I: mhm) but there's also a way of approaching situations (I: yes) that um if you can talk the talk (I: mhm) you come across as switched on intelligent da-da-da you get far more than somebody who sits there wringing hands and says 'oh I cannae do a thing wie him doctor you've gotta gie us something for us' (I: yes) and there's loads of families out there that have been given the medication route and *that's it* and left with it (: mhm) without being give all the other options (.) I don't think there's (.) there's a lot of children undiagnosed because 'well what do you expect from a family like that (.) of course the child's off the wall (.) he's not getting the proper discipline (.) nurture= (I: =right) […] yeah you know you're judged for your family you know that um being judged 'well we won't possibly do any behavioural improvements because well we can't understand it or (I: oh) aye you know so we'll just give them medication there you go off you go (.) it's simple for everybody to pop a pill (I: yes mhm) and it's not really addressing all the other issue that go alongside ADHD […] my last meeting with Adam's paediatrician um (.) I'm telling her things these days it's actually peeving me off […] because her only (.) she's so unimaginative (I: mhm) her only option is (.) medication (I: right) and at the end of *every* consultation (without fail) she always says 'well there's always medication' (I: right) and I pointed out to her this time round (.) I wonder if there's anything (.) because I'm also following a nutritional path as well for Adam […]

In the above lengthier extracts about other treatment options and medication, there is a lot that is happening. The analysis here focuses on the similar subject positioning achieved in the constructions which can be heard as distinctly different to the earlier extracts. What is distinct about the extracts is that they offer contrary accounts about medication. In both extracts medication can be heard as being offered from the paediatrician. In extract 16 this is seen with Mr McKay's: "the last time my wife was down she more or less told her that she was putting Liam on them" (lines 3-4) and: "'well I'll give you leeway of three months or so'" (lines 6-7). This is heard as a strong coercive attempt in this account by the paediatrician which is epitomised by: "trying to *force* (I: yeah) these tablets on er my son basically our son" (line 12). Against this attempt, the parental resistance to such medication is

heard with: “aye well my wife said ‘well we’re not to keen on them at all’” (line 6) and (in response the interviewers question about whether the doctor knew about the parents views about the medication, not produced here) “aye she does know she does know that we’re not wanting em Liam on well we don’t want Liam on (.) Ritalin (I: yes)” (line 16-17). In this account further, an alternative option to the medication is evident with: “I’ll only try (.) natural medicine and we’ve told her that” (lines 17-18). In extract 17 a similar construction emerges with the offer of medication by the paediatrician: “because her only (.) she’s so unimaginative (I: mhm) her only option is medication (I: right) and at the end of every consultation (without fail) she always says ‘well there’s always medication’” (I: right) (lines 18-21). Here the persistent attempts by the paediatrician to dispense medication resemble the efforts by the paediatrician in extract 16. Mrs Morrison’s refusal and attempts in the face of this appear with: “I’m telling her things these days it’s actually peeving me off “(line 18) and later “I pointed out to her this time round (.) I wonder if there’s anything (.) because I’m also following a nutritional path as well for Adam […]” (lines 21-22). Here it’s clear that the “nutritional path” represents an alternative option as pursued by Mrs Morrison.

What is further significant about these extracts is the construction of identity achieved. In the last lines of extract 15 quoted above, Mrs Morrison achieves an identity of a knowledgeable parent in the face of “unimaginative” and limited options by the paediatrician. This was also oriented to earlier in the extract with the anecdote about prejudice: “ it’s a *battle* to get resourcing for children (I: mhm) there are finite amounts of resources (I: yes) so the one who shouts the loudest gets (I: mhm) but there’s also a way of approaching situations (I: yes) that um if you can talk the talk (I: mhm) you come across as switched on intelligent da-da-da you get far more than somebody who sits there wringing hands and says ‘oh I cannae do a thing wie with him doctor you’ve gotta gie us something for us’” (lines 3-8). Here the significance of an intelligent identity is invoked as crucial in determining the services obtained with Mrs Morrison’s identity clearly indicated as “switched on intelligent”. The next turn of: “and there’s loads of families out there that have been given the medication route and *that’s it* and <u>left</u> with it (I: mhm) without being given all the other options” (lines 8-10) is reminiscent of the earlier extracts 12-13. The orientation to family prejudice is seen with: “’well what do you expect from a family like that (.) of course the child’s off the walls (.) he’s not getting the proper discipline (.) nurture” (lines 11-12) and “’well we won’t possibly do any behavioural

improvements because well we can't understand it or (I: oh) aye you know so we'll just give them medication there you go off you go'" (lines 13-15). Here it is clear that intelligence and family factors are seen as key in the "battle" to get resources. Medication is therefore oriented to as the easy solution for families by paediatricians and so resistance requires great work. In addition, the notion of the 'good parent' is heard here further in relation to gaining resources. In extract 16, Mr McKay invoked his wife's strength in the face of such coercion with: "some people with maybe less stre (.) less willpower than my wife's let's just say might have gave in and said 'well oh ok then'" (lines12-14). Thus, while these were complex extracts, they are significant in the contrary positioning of the parents in the face of medication. Clearly both extracts oriented to the notion of alternative options (natural medicine and a nutritional path). However, this also involved the presentation of an identity of resistance to the efforts by the paediatrician to enforce such medication. Both extracts oriented to personal characteristics (willpower in extract 16 and intelligence in extract 17) in order to resist such efforts and pursue these alternative options. It was clear that there was great discursive effort involved in such narratives of 'resistance'. Thus, unlike the earlier extracts then, treatment choice (i.e. of medication and pursuing alternative options) is presented in the face of resistance. Such treatment choice was also associated with identity constructions of inner qualities of the parents (i.e. strength and willpower; intelligence and being switched on). This gives these accounts an almost heroic picture in relation to parental efforts, which is again consistent with the overall 'good parent' identity.

In sum, treatment choices in parental talk about medication highlighted two ways of talking about medication. The first included constituting the treatment choice as being driven by outside, external factors relating to being desperate and not having any other options. The second was talk about medication as refusal in the face of coercive efforts. Such treatment choice arose out of the personal inner qualities of the parent in the face of such influences (i.e. as strong, having willpower and intelligent and resourceful). This second construction enabled the construction of the overall 'good parent' who appeared in these accounts in heroic terms. In the first construction however, while clearly a passive position, parents were clearly not personally responsible. The notion of 'being at wits end' then, appeared in stark contrast to having 'options' in terms of parents' subject positioning in relation to the medication. These passive and active positions were temporally invoked in relation to alternative options to medication.

Conclusion

This analysis has focused on parental talk about their children's difficulties from parents with children diagnosed with ADHD. The analysis highlighted how parental talk deployed both a Biological repertoire and an Environmental repertoire in accounting for the origins of the difficulties, either as a genetic condition or due to a range of parenting influences. What was significant about this was that these repertoires were largely consistent with biopsychosocial explanations for ADHD generally, but that they appeared here as discrete and fragmented explanations in the narratives. These contradictory repertoires implied competing subject positions for parents in terms of accountability and thus talk about diagnosis was seen to do 'good parenting' work in order for the child's difficulties to be constituted as biological and attend to an identity of the 'good parent'. This implied that parental accountability and responsibility in ADHD, rather than being exonerated by a diagnosis of ADHD as suggested by previous qualitative research, was a temporal accomplishment achieved discursively. This required great discursive effort in these accounts. Additional findings from the analysis highlighted how parents were able to attend to the availability of competing explanations for the child's difficulties as attributed here to schools and families. The parallel was drawn here with parents as lay people, who could be seen to be making similar use of Gilbert and Mulkay's (1984) empiricist accounting device, so that competing versions of ADHD were dismissed as due to dispositional aspects such as bias and ignorance. In contrast, the Biological repertoire appeared here in relation to expert opinion and authority, which in time – like cancer – would get 'out there' and be disseminated so that such ignorance was dispelled. Finally, parental positioning in relation to medication talk was explored. The analysis showed how parents were variously positioned either as passive recipients of the medication, with very little choice exercised and being in a desperate state. Alternatively, parental positioning occurred as the exercising of an active choice, with a range of other 'options' available. However, in relation to this, parents' positioned themselves as engaged in active resistance to the medical professionals' insistence on medication.

Chapter 7: Analysis of Teacher Accounts of Children's Difficulties

Introduction

This chapter is an analysis of teacher accounts about children's difficulties diagnosed as ADHD, from semi-structured interviews, following a 'critical discursive psychology' approach as applied in the previous chapter. Here, too, the focus was on the culturally available ways of talking about this topic for teachers which was framed by the *interpretive repertoire, subject positions* and the *ideological dilemma*. There are three sections to the analysis. In the first section, consistent with this approach, teacher accounts were examined in order to identify the use of interpretive repertoires in talk about children's difficulties. These entailed contradictory subject positions for teachers and section two focuses on how teachers were able to resolve the tensions inherent in such accounts. In the final section, the analysis examines teachers' accounts of (mis)diagnosis and (mis)treatment which is largely heard as an alternative explanation for children's difficulties. The teacher analysis was concerned with similar types of data that occupied the parent analysis, data about accounts for children's difficulties as well as constructions and origins of ADHD.

Teacher accounts for Children's difficulties

Two opposing interpretive repertoires were discernible in teachers' accounts which were contradictory and used simultaneously in the interviews. The following data arose from the interviewer's question of: *What does ADHD mean from your perspective.* While there was a lot going on in these extracts, the analysis focuses on the identification of patterns of talk here and the simultaneous use of both repertoires. It is recognised that these extracts are embedded in a context of contrast and distinction, but they are examined in turn according to the ADHD repertoire and the Not ADHD repertoire which was hearable in the following extracts.

Extract 1

Teacher Interview 3: Head Teacher of Sunnyville Primary

I: What does ADHD mean from your perspective
T: *well* er this this is it I mean (.) it seems to be a very sort of flexible kind of (.) definition em (.) for for example I have I have one child in the school who (.) to me he seems to be a kind of (typical) case perhaps (.) you know somebody who can't sit still who can't pay attention er needs to fiddle around an and things like that so (.) and then er sometimes finds his behaviour difficult to control you know er they they can get (.) they don't like to do something which is not of their choosing and things like that so er (.) I suppose that (.) that would be my (.) that's how I would see a child with ADHD (I: mhm) but er quite difficult to sort of pin down because some (.) some of the children you sometimes feel that (.) they just can't help themselves that's just the way they *are* that's just what they're like (.) and and others you *do* feel that it's a more (.) calculated sort of situation um (.) and and they can be (.) a bit more manipulative (I've had children) say to me before em (.) and I've heard (.) I know other teachers in other schools have similar experiences er (.) 'I can't help it I've got ADHD' which you know (I: yes) so er that does happen from time to time

Extract 2

Teacher Interview 6: Deputy Head Teacher & Subject Specific Teacher of Harriston Primary

I: what does ADHD mean from your perspective
DHT: […] but mainly I suppose it's about (.) dealing with children as individuals and finding out as the classroom teacher what works for that child (I: yes) em but also knowing that what worked yesterday (.) might not work today (I: yeah) you know so it's a lot of thinking on your feet basically (I: yeah) and em quite a lot a' negotiation with that child (I: mhm) em sometimes too much negotiation cos I think we bend over backwards (.) sometimes to to you know accommodate=
SST: =and the further we bend the further they'll push us
DHT: =children and sometimes it is difficult to get the balance right between what is that child manipulating and (I: mhm) and what is (.) are real genuine difficulties (I: yes um) so it's about (.) again *knowing* the child (I: mhm)
SST: there's a difference between someone that *can't* and someone that *won't* (.) […]

Extract 3

Teacher Interview 4: Head Teacher of Greenwood Primary

[The head teacher was describing a pupil with ADHD at her school. She had previously likened an episode of the pupil's behaviour to a scene from the film: The Exorcist (a film about demonic possession). This was followed by detailed strategies that the school was using in order to deal with his behaviour. She then went on to describe an incident in which she observed the pupil in arts and crafts].

I: What does it [ADHD] mean from your perspective
T: […] (.) he spent a *huge* amount of time doing it
I: intricate
T: uh huh (.) but the concentration as well (.) I thought well (.) if he's truly ADHD (.) how can he (.) do such things and and take so long and work so hard at it (.) and absolutely focus absolutely focused (.)
I: (.) so moving on from that do um you think there's value in having this diagnosis called ADHD
T: I don't know (.) I think I think it's slightly less now (.) there was a spell where every child (.) it seemed to be (laughs) at one point I would say we would have the best part of ten children (.) in that situation (.) six or seven children
I: in the school
T: in the school (.) it was a trooping down the stairs to the office where the medication (.) and I I have met children who I would say to you *yes* this is not normal this is not a child that is just naughty or a child who can't concentrate this is a child that is beyond all of that (I: oh right) I have seen children like that (I: yes) but (.) too often I think (.) and and this is discussed around colleagues in other schools in the local area (I: yes) that there are diagnoses of ADHD and the medication (.) when we've thought (.) well (.) *why* (laugh) what is this about
I: so is it almost inappropriate
T: yes and I'm not (.) I'm not saying there's not such a thing (I: yes) because I'm sure there is and I have seen children who just do not have control at all (.) they *cannot* even when they want to (.) they can't

Extract 4

Teacher Interview 5: Class Teacher of Greenwood Primary

I: What does it [ADHD] mean from your perspective
T: (.) um (.) it's fairly new to me (I: mhm) um (.) I've been back into teaching [some years] […] (.) it's fairly new (.) um maybe I'd I'd I had dealt with it before before I stopped teaching you know […] (I: yes) but em I don't think it was then been labelled as ADHD (I: right yes) it was probably just you know the naughty boy in the corner sort of thing so as I said it's it's (.) fairly new (.) I certainly *do* have a pupil at the moment um (.) who has major problems within the classroom and has been diagnosed as ADHD (I: mhm) um and (.) you know he's very disruptive um (.) but I've got to remember you know there is there is a cause for it and I find *that* (.) that's the biggest um quandary I have is just remembering that you know he he has this and I've got to make allowances (for it you know) (I: yes) because a lot of it just does appear as (.) bad behaviour (I: right) bad behaviour
I:[what in particular]
T: well just his whole behaviour within the classroom (I: oh) you know if another child was that hasn't been diagnosed was to do the things this particular child does then (.) you know it would be bad behaviour on their part but because he he has been diagnosed um you know there is a reason a reason for it (I: mhm) and having said *that* I think there is a lot of um (.) you know behaviour issues that come along with it (.) you know I don't think you can put it all down to his ADHD (I: yes) um (.) () I don't know I mean you'll know yourself um that there's still a lot of research going into it (I: yes) you know um (.) so yes so really I'm sort of finding my feet at the moment as well cos really it's the first time I've had to deal with with a child that's been diagnosed

[And later in the interview T5 returns to this when offered an opportunity to comment on any issues to do with having a pupil with ADHD in the classroom]:

T:[…] so it's the *balance* trying to get the balance right (I: yes) um (.) that's one of the most difficult things (I: yes) you know just how much is due to his condition (I: mhm) and how much is him just you know pushing us as far as we'll go (I: yeah) you know cos he's a bright enough little boy (I: oh yeah) you know so I think he could also use his condition you know to push us (.) see how much he can get away with so it's really just you know trying to find that balance

The 'ADHD' repertoire

There is clearly an orientation and deployment of an 'ADHD' repertoire in the above extracts 1-4. This is largely made available through the interviewer who introduces talk about 'ADHD' into the interaction in order for teachers to manage this. Talk orienting to the ADHD repertoire can be seen to be invoked as one side of a contrast that is created in the accounts. The question: "what does ADHD mean from your perspective" introduces ADHD as a topic which requires attending to. It is evident as a relatively open question in that no presumed 'reality' of ADHD is declared by the interviewer. From the above extracts it's clear that there are three discursive features associated with this repertoire. Firstly, there is evidence that teachers orient to this question as problematic. In extract 1, lines 2-3, the head teacher's: "*well* er this is it I mean (.) it seems to be a very sort of flexible kind of (.) definition…", can be heard as the start of an initial account about troubles telling, signalled by the emphasis on 'well' (Pomerantz, 1984a). The use of 'flexible' is also hearable as in contrast with something fixed which works to problematise ADHD here, along with "this is it". Later in line 9 the use of: "but er quite difficult to sort of pin down…" is a further reference to the problematic status of the request. In extract 3, the head teacher during the course of the narrative declares in line 4: "I thought well (.) if he's truly ADHD (.)…" orienting to a case of ADHD as troubling and problematic (this is further discussed below). In extract 4 the class teacher also orients to the status of the questions as a problematic one when in line 4-6 she states: "but em I don't think it was then been labelled as ADHD (I: right yes) it was probably just you know the naughty boy in the corner sort of thing…". This works to draw attention to the relative history of the ADHD construct, where "labelled as ADHD" exists as an alternative to the equally valid "naughty boy in the corner". The use of: "that's the biggest um quandary I have is just remembering that you know he he has this" (lines 9-10) enables an explicit invocation to 'ADHD' as problematic.

Later in line 20-21, this is echoed with: “I mean you’ll know yourself um that there’s still a lot of research going into it (I: yes) you know um”. This can be seen as an attempt to further problematise the question about ADHD and which works to invoke the interviewer into achieving consensus for the controversial status of the condition.

In the second instance, there is a turn to specific instances of talk about ADHD. In extract 1 lines 3-9, the head teacher is able and turns to offer an example of a child with ADHD as: “I have one child in the school who (.) to me he seems to be a kind of (typical) case perhaps (.) you know somebody who can’t sit still who can’t pay attention er needs to fiddle around an and things like that so (.) and then er sometimes finds his behaviour difficult to control you know er they they can get (.) they don’t like to do something which is not of their choosing and things like that so er (.) I suppose that (.) that would be my (.) that’s how I would see a child with ADHD”. In extract 3, the head teacher too orients to a description of a specific child diagnosed with ADHD. In this narrative about the child, the status of ADHD is problematised (this is discussed further in the next section). However, what is noteworthy here is that the head is able to offer examples of other children diagnosed with ADHD: “…I I have met children who I would say to you yes this is not normal this is not a child that is just naughty or a child who can’t concentrate this is a child that is beyond all of that (I: oh right) I have seen children like that (I: yes)…” (lines 14-16). [In light and proximity of the overall context of this extract however, this appears as a concession because her turn is occupied with a description of a pupil dubiously labelled as ADHD (as described in more detail in the next section). What is significant here is that an apparent concession is made to the ADHD repertoire as a condition specifying children that are: “not normal”. This appears largely in comparison to children who are merely: “just naughty or a child who can’t concentrate”]. In extract 4 the class teacher orients to the ADHD repertoire with a specific pupil: “I certainly *do* have a pupil at the moment um (.) who has major problems within the classroom and has been diagnosed with as ADHD (I: mhm) you know he’s very disruptive um…” (lines 6-8).

Finally, the notion that the child has a medical condition with genuine, enduring difficulties is hearable as a characteristic of this repertoire. In extract 1, the head’s turn in line 9-11 of: “some of the children you sometimes feel that (.) they just can’t help themselves that’s just the way they are that’s just what they’re like….” establishes a constitutional explanation here. Extract 2 demonstrates a similar deployment of the ADHD repertoire with the use of: “real genuine difficulties” (line

10) by the deputy head teacher and by: “a child that *can't*” (line 12) by the subject specific teacher. Again, extract 3’s use of: “yes this is not normal this is not a child that is just naughty or a child who can’t concentrate this is a child that is beyond all of that” (lines14-16), invokes the notion of genuine and enduring difficulties. Extract 4’s reference to:“…there is there is a cause for it…” (line 9) and: “he has this…” (line 11) orients to what can heard as a discrete condition.

In summary, an ADHD repertoire was invoked in teacher accounts for children’s difficulties. The ADHD repertoire was characterised here as reference to notions of a genuine medical condition (i.e. as “can’t”, “not normal” and “beyond” general naughty behaviour exhibited by children). This repertoire appeared in relation to *specific* examples or instances of ADHD which the teachers invoked here in order to account for ADHD (i.e. as “one child in the school”, “some of the children” (extract 1), “I have seen children like that” (extract 4)). In addition, it was clear that orientations to the interviewer’s request about ADHD were somewhat problematic and what is noteworthy is that when ADHD was introduced in these extracts by the interviewer as a topic, teacher accounts produced dichotomous versions for children’s difficulties. One side of the dichotomy involved the ADHD repertoire while the other involved an alternative explanation. This is examined in further detail below.

The ‘Not ADHD’ Repertoire

Against an orientation to the ADHD repertoire is a simultaneous orientation to what is called the NOT ADHD repertoire. Central to this repertoire, it is argued that talk is actively engaged in doing *not ADHD* discursive work. In other words, constructions which provide alternative explanations for children’s difficulties are offered here. As noted above, this is significant because these explanations are offered in the face of so called diagnoses of ADHD. In the ADHD repertoire it was evident that children’s difficulties could be accounted for according to a genuine medical condition and was offered in relation to specific instances furnished by teachers. In the Not ADHD repertoire, by contrast, different discursive characteristics are displayed. There are two main features of interest which will be discussed.

Firstly, an alternative account for children’s difficulties is hearable from these accounts as temporal difficulties rather than a medical condition. In extract 1, juxtaposed against the example of the “typical case” of ADHD, is the further “and others” as seen in: “and and others you *do* feel that it’s a more (.) calculated sort of

situation um (.) and and they can be (.) a bit more manipulative…" (lines 11-12). The notion of temporal or manipulated difficulties is echoed in extract 2 in the co-construction with the deputy head and the subject specific teacher: "…and sometimes it's difficult to get the balance right between what is that child manipulating and what (I: um) what are (.) are real genuine difficulties…" (line 9-10). This is echoed by the subject specific teacher's: "there's a difference between someone that *can't* and someone that *won't* (.)" (line 12). The orientation to deliberate manipulation or difficulties epitomised by "won't" invoke conscious control by the children and so implicate temporal behaviour. In addition, what is distinct here about these temporary behaviour displays is that they can be heard as clearly *not instances of ADHD*.

In extract 3 there is further evidence for the Not ADHD repertoire, which while different to the previous extracts, can be seen to be engaged in similar discursive work. This is a more complex extract which will be outlined further. This extract is concerned with the explication of an example of a pupil with ADHD in the school. Prior to this extract the head had jokingly likened an episode of behaviour exhibited by this pupil to a scene from the film The Exorcist (which is concerned with demonic possession!). This followed a description of her observations of the pupil at work in arts and crafts and very clearly an orientation to the Not ADHD repertoire with: "…he spent a *huge* amount of time doing it (I: intricate) uh huh (.) but the concentration as well (.) I thought well if he's truly ADHD (.) how can he (.) do such things and take so long and work so hard at it (.) and absolutely focus absolutely focused…" (lines 2-6). A similar orientation to the topic of ADHD is being worked up in this extract, like extract 1, because what is worked up as significant from the head's description is the concentration exhibited by the pupil: "but the concentration as well (.)". The description is presented of the pupil's behaviour at work in arts and crafts which appears, and is hearable, as in stark contrast to the classic and typical ADHD pupil – i.e. that they are unable to sit still and concentrate for long periods of time. In contrast to this classic ADHD picture, the head builds a picture of the child working diligently on his project and as someone that was "absolutely focus absolutely focused" (line 6), notice the repetition for emphasis. Further, "absolutely focus absolutely focused" is reminiscent here of Pomerantz's (1986) extreme case formulation of the child's activities as extremely focused within a context of complaint and may additionally highlight the teachers' indexical investment in aligning with this Not ADHD repertoire (Edwards, 2000). In this description there is

an element of the incredulous and wonder by which the head is presented with this 'evidence' of a (so called) ADHD child at work. The detail of the extract is not presented here (in order to protect anonymity) but the head engages in very detailed reports of the project that the child was engaged in. Thus what is significant here is that it was not *just* that the child was able to concentrate for a few minutes on a task, but the lengths present in the extract of the child's almost excessive concentration, function to present a stark and opposing picture of the typical child with ADHD. Again, like the previous extracts, the effect is to simultaneously make available the contrary notions of a typical ADHD child with that of non-ADHD behaviours like extreme concentration. It does this in order to work up and achieve incredulity for the behaviour and can be seen to be doing *not ADHD* work. Thus it is logically possible to question the status of the pupil as ADHD. This is seen emphatically in: "if he's truly ADHD" (line 4) in which the head articulated the Not ADHD repertoire.

Similarly in extract 4 there is also the use of the Not ADHD repertoire, like in the previous extracts. This occurs in various ways. The normalising of children's behaviour and the problematic status of ADHD was already seen in the above discussion which worked to offer an alternative to a medical explanation (i.e. as seen in "it was probably just you know the naughty boy in the corner sort of thing" (line 5-6); "labelled as ADHD" (line 4-5)). This had a similar function to extract 1's "flexible definition" and extract 4's "if he's truly ADHD" in working up a problematised orientation to ADHD. The class teacher's account furnished a description of a pupil diagnosed with ADHD in her class (as described above). Despite this diagnosis, an alternative explanation is achieved here with: "…because a lot of it just does appear as (.) bad behaviour (I: right) bad behaviour…"(line 11-12). Again there is an orientation to a construction of normal, temporary childhood behavioural difficulties as opposed to a medical condition. There is further evidence of *not ADHD* discursive work in operation with: "…I think there is a lot of um (.) you know behaviour issues that come along with it (.) you know I don't think you can put it all down to his ADHD…"(line 18-19). This turn is significant because the teacher works up "behaviour issues" as important in accounting for the child's behaviour rather than ADHD. These "behaviour issues" achieve priority in this extract over the medical account.

In addition to the use of not ADHD discursive work, as discussed above, there is a further feature that is significant associated with this Not ADHD construction. Unlike the ADHD repertoire which appeared in relation to specific instances or examples,

the Not ADHD repertoire appears here as a generalised feature. In extract 1 this is evident with: “(I’ve had children) say to me before em (.) and I’ve heard (.) I know other teachers in other schools have similar experiences er (.) ‘I can’t help it I’ve got ADHD’ which you know (I: yes) so er that does happen from time to time…” (lines 13-15). Extract 3 is reminiscent of this with an orientation to support from other schools with: “..but (.) too often I think (.) and and this is discussed around colleagues in other schools in the local area (I: yes) that there are diagnoses of ADHD and the medication (.) when we’ve thought (.) well (.) *why* (laugh) what is this about” (line 16-19). In these extracts then, accounts of manipulated or temporal difficulties are worked up as a widespread and generalised phenomenon. Finally, in extract 4, the generality of the pupil’s behaviour is invoked when the interviewer probes for further talk about this type of behaviour. The class teacher goes on to describe the pupil’s behaviour with: “well just his whole behaviour within the classroom…”(line 14). An all-encompassing and general “his whole behaviour within the classroom” is invoked as problematic rather than specific aspects with the pupil. Finally, as noted above the class teacher orients specifically to the status of ADHD research following this with: “…I don’t know I mean you’ll know yourself um there’s still a lot of research going into it…” (line 19-20). This claim worked to undermine the notion of ADHD as a genuine medical condition and here the teacher aligns herself to the controversial status of ADHD with an appeal to the interviewer and commonly shared understandings about this controversial condition. These effects worked to achieve the Not ADHD repertoire as general and widespread.

In summary, it is clear that extracts 1-4 shared a number of discursive features in relation to accounts which produced the Not ADHD repertoire. Although the extracts were different and there was a lot going on in these extracts, it is clear that they were actively engaged in doing *not ADHD work.* Central to this repertoire was the construction of children’s behavioural difficulties in a normalised fashion and temporal rather than as a medical condition. In addition this was worked up as a general and widespread occurrence through reference to other schools and the use of plurals. This was heard in contrast to the specific instances of genuine ADHD. Clearly the simultaneous deployment of the repertoires occurred as a dichotomy as mentioned above. Within the context of the interview, great discursive work was evidenced on the part of the teachers in order to produce such non-ADHD accounts as seen in the Not ADHD repertoire.

Subject positions for teachers

In the previous section it was argued that teachers' accounts deployed the simultaneous use of the ADHD repertoire and the Not ADHD repertoire to account for children's difficulties. TABLE 1 is a graphic summary of these repertoires as they appeared in the earlier data extracts. The table is used for illustrative purposes of the workings of the various repertoires and is thus not meant to be exhaustive. Reference to teacher interview numbers is made in parenthesis with some examples from the data extracts.

TABLE 1: TEACHER ACCOUNTS FOR CHILDREN'S DIFFICULTIES

Repertoire	Context for the child's difficulties	Teacher subject position available
The ADHD repertoire • **specific instances**	***1. Genuine medical condition (can't)*** (typical) case (T3) Condition (T5) The way they are (T3) Real genuine difficulties (T6) Not normal(T4)	***2. Passive position*** 'I can't help it I've got ADHD' (T3) Sometimes too much negotiation (T6) Bend over backwards (T6) Push us (T6; T5) Fairly new (T5) Make allowances (T5) Still Finding my feet (T5)
The Not ADHD repertoire • **generalised**	***1. Temporal child difficulties ('won't)*** Manipulated (T3; T6) Calculated (T3) won't (T6) naughty boy in the corner (T5) bad behaviour (T5) behaviour issues (T5)	***2. Active control*** Dealing with children as individuals (T6) A lot of thinking on your feet (T6) Negotiation (T6) Knowing the child (T6)

TABLE 1 highlights the subject positions made available for teachers as a result of using the repertoires. It is argued that the Not ADHD repertoire and the ADHD repertoire offer contradictory and opposing subject positions for teachers. The above analysis highlighted that in the ADHD repertoire, the child's difficulties were

accounted for in terms of a genuine medical condition of ADHD. In the Not ADHD repertoire on the other hand, the child's behaviour was accounted for by a range of alternative explanations which implied temporal childhood behaviour. Central to the ADHD repertoire was a subject position entailing a passive response. This implied that teachers were required to be passive and suspend active efforts and control in the classroom, in the face of this medical condition. This is epitomised by such metaphors in the table as: "bend over backwards"; "make allowances"; and the idea that teachers were being "pushed" or "manipulated". Clearly the active agent in this repertoire is the child, and the teachers the passive recipients. In the contrary Not ADHD repertoire, a different subject position is made available. Here the teacher is being invoked as an active agent in terms of power, control and expertise. Teacher expertise, empowerment and control are implicated through: "dealing with children as individuals", "knowing the child". Thus the various subject positions available to teachers entailed: a largely passive response (whereby power and control in the ADHD repertoire are suspended) versus an active response (whereby the teacher is able to exercise power and control in the classroom for the Not ADHD repertoire).

The subject positions available for teachers in relation to the different repertoires can be further exemplified in relation to an example of one of the metaphors used in the extracts. In TABLE 2 below, the metaphor of being on your "feet" is illustrated in relation to the repertoires.

TABLE 2: TEACHER SUBJECT POSITIONS: A METAPHOR FOR CONTROL-BEING ON YOUR "FEET"

Repertoire	Metaphor	Subject Position
The ADHD Repertoire	***Still finding my feet*** (T5)	Inexperience and non-expert: **Passive/Disempowered**
The Not ADHD Repertoire	***A lot of thinking on your feet*** (DHT, T6)	Experience and expertise: **Active/Empowered**

The subject positions made available to teachers in relation to issues of empowerment and control are clearly exemplified in relation to the metaphor used above. In extract 2, line 5, the deputy head teacher refers to: "a lot of thinking on your feet" in relation to dealing with children as individuals. In extract 4, line 21, by

contrast, the class teacher refers to “finding my feet” in relation to dealing with a pupil diagnosed with ADHD. These will be further discussed below.

From the above table and the extracts, the metaphor of being on your “feet” clearly appears in these extracts in relation to teaching and to issues of control and empowerment. In relation to “a lot of thinking on your feet”, the deputy head teacher has been engaged in working up a series of strategies that are used for dealing with children with difficult behaviour which she generalises to all children. The list is concluded with reference to “a lot of thinking on your feet” in order to deal with and discriminate between manipulated and genuine difficulties (which appears later). Thus “thinking on your feet” is tied to the abilities and expertise of the classroom teacher in relation to difficult behaviour in this extract. It is this “thinking on your feet” as tied to expert knowledge of individual children which is signalled as crucial here in relation to the teacher’s capacities. In extract 4, the class teacher makes use of: “still finding my feet” in relation to her apparent lack of experience in dealing with diagnosed ADHD. This is temporal however, because in her earlier construction at the start of the extract, she had simultaneously oriented to a position of knowledge in having dealt with the: “naughty boy in the corner” in her previous teaching and which she had worked to equate with ADHD. This was in contrast to being “fairly new” to ADHD. Thus “still finding my feet” here can be seen as an orientation to the subject position of inexperience and clearly a lack of knowledge and expertise, unlike the previous construction. It is clear then that the contrary positions available to teachers are as experts in terms of knowledge versus inexperience and a lack of knowledge. The subject positions of expertise versus non-expertise are clearly tied to teacher empowerment in terms of difficult behaviour.

Metaphors are important from a discourse analytic perspective in terms of the function that they perform in talk. Hence, the function of the present metaphor of “feet” is significant and further considered here. Drew and Holt (1988), for example, showed how the use of idioms were used in naturally occurring talk and were a particularly robust device in terms of summarising a particular position and achieving legitimacy for this position. The idiom functioned in making the position difficult to counter and occurred in that data in making complaints. The relevance of this work to the teacher extracts here is that it’s clear that teacher accounts sought similarly to summarise their position in relation to the topic of ADHD and worked to achieve legitimacy for this position. While everyday talk has been shown to be argumentative and rhetorical (Billig, 1987; 1991), talk about a controversial topic such as ADHD

may be expected to be especially argumentative due to the ready availability of counter-positions. One way around that then is to summarise and bring to a close a particular position in order to minimise such possible countering by the interviewer. While Drew and Holt's (1988) study was primarily concerned with complaints, the teachers accounts here may be similarly heard as attending to occupational difficulties associated with teaching. Further, Drew and Holt (1988) noted that the use of idioms was specific to what they called 'inauspicious environments', where the recipient had up until that point withheld support or sympathy for that position. In the context of the research interviews with teachers, the interviewer likewise had withheld a position relating to this highly contested topic, and thus an effective means of attending to this may have been through the use of such metaphors in order to achieve legitimacy for such accounts and prevent counter positions. Finally, if being on your "feet" is a metaphor which can be used to refer to the repertoires as shown in extracts 2 and 4, then the extension of this metaphor is also significant – the notion of being on your "feet" and its relationship to being balanced as used in these extracts worked to extend this metaphor. The extension of this metaphor to a commonly used idiom is considered further in the next section.

Summary

A Not ADHD repertoire and an ADHD repertoire were deployed simultaneously in teachers' accounts for children's difficult behaviour. In the ADHD repertoire, children's difficulties were accounted for due to a genuine medical condition. In the Not ADHD repertoire, by contrast, teacher accounts worked to construct such difficulties as largely due to everyday temporal childhood behaviours. These occurred in relation to specific instances for the ADHD repertoire, or were worked up as generalised occurrences, as in the Not ADHD repertoire. In addition, these repertoires entailed contradictory subject positions for the teachers. In the ADHD repertoire, teachers were passively positioned as non-experts and inexperienced. The Not ADHD repertoire, however, entailed a subject position of the active agent in terms of expertise, knowledge and power in relation to children's behaviour. The use of the metaphor of "feet" was associated with these repertoires and deployed in relation to teacher's empowerment and control of management of the classroom situation. The use of this metaphor worked to achieve legitimacy for the teachers'

position against possible counter positions from a non-committal interviewer and to bring such troubles-telling to a close.

'Getting the balance right': Teacher empowerment as an ideological dilemma

As was highlighted in the previous sections, teachers' accounts for children's difficulties simultaneously made use of a Not ADHD repertoire and an ADHD repertoire in which the difficulties were constructed variously as manipulated and temporal or as genuine in nature. The way in which they were constructed had differing implications for teachers in terms of subject positioning. In the ADHD repertoire, the teacher was passive and responsive to the child's condition and also positioned as inexperienced. In the Not ADHD repertoire, by contrast, the teacher was positioned as an expert that is required to assume control for such childhood behaviours as manipulation and "pushing" and thus could be said to be empowered in terms of knowledge and expertise. There is a clear ideological dilemma for teacher talk surrounding teacher empowerment as experts of child behaviour, versus being disempowered in the face of a medical condition such as ADHD. Such an ideological dilemma rests on drawing on the competing ideologies of medical conditions and educational discourse as epitomised by the interpretive repertoires. Central to this ideological dilemma is the negotiation and attending to teacher empowerment or expertise and knowledge in children's difficult behaviour. Clearly if children's difficulties can present as a genuine condition (as in the ADHD repertoire) but also as temporal or manipulated difficulties (as in the Not ADHD repertoire), then there is an ideological dilemma for teachers in terms of their own role and empowerment. This ideological dilemma rests on such passive features as: "making allowances" or "bending over backwards" versus the active efforts of the teacher in "knowing the child" and "negotiation". Billig et al (1988) highlighted the more general ideological dilemma for teachers and educational practices inherent in competing ideologies in contemporary society concerning: respect for authority and expertise versus egalitarianism and democratic principles. It is argued that in relation to specific talk about ADHD, that the ideological dilemma is manifest here in terms of teachers' empowerment in relation to action. There is evidence in the previous extracts for the orientation to this ideological dilemma and is thus reproduced here as:

Extract 2:T6: DHT & SST

DHT: […] and **sometimes it is difficult to get the balance right** between what is that child manipulated and (I: mhm) and what is (.) are real genuine difficulties […]

Extract 3: T5: CT

T: […] so **it's the balance trying to get the balance right** (I: yes) um (.) that's one of the most difficult things (I: yes) you know just how much is due to his condition (I: mhm) and how much is him just you know pushing us as far as we'll go […]

It is clear from the above that teachers' accounts are oriented to the ideological dilemma of power and control in relation to children's difficult behaviour. This is an inherent ideological dilemma requiring resolution and which is epitomised by: "get[ting] the balance right" (as highlighted above). This can be seen as an extension of the "feet" metaphor described above. If being on your "feet" can be used to refer to classroom teaching and control, then clearly it is necessary to stay balanced in the face of challenging situations. Hence the importance of: "get[ting] the balance right" when it comes to such behaviour and discriminating between the repertoires. It is clear that teachers are required to balance the expectations of a genuine difficulty by "making allowances" as well as the expectations of a manipulated difficulty with issues of accountability for behaviour. In other words, it's clear that teachers are required to negotiate their own active role and expertise in the area of children's difficulties – between making allowances for a genuine difficulty (a lack of control) and between enforcing accountability for behaviour (control and authority). The significance of metaphors and idioms in discursive approaches was further highlighted in Billig and MacMillan (2005)'s example of the 'smoking gun' metaphor in media reports. The authors drew on Gucksberg's (2001) attribution model, to highlight how the passage from metaphor to idiom may occur. Such passage to idiom essentially entailed the literal use of a metaphor in common or standard use of language rather than solely metaphorical. This is relevant here because it demonstrates how the extension of the "feet" metaphor to the idiomatic "get[ting] the balance right" is part of everyday language about teaching and so further works to achieve this position as indisputable and difficult to counter. This is significant in the context of controversy where counter-positions are always potentially available. The following extracts about the origins of ADHD explore how

the ideological dilemma about teachers' negotiation of empowerment and expertise is negotiated.

Extract 5

Teacher Interview 7: Deputy Head Teacher of Newville Primary

[Prior to this the interviewer had asked what ADHD means and the deputy head teacher had been describing difficulties with focusing, communicating to peers and being distracted].

I: […] and how do you think a child comes to be like that [ADHD type behaviour]
T: is this my personal opinion (laughs)
I: yeah (.) your theory (.) your your ideas
T: (.) well I don't know I'm very much in two minds about it because (.) I think you know there seems to be an awful lot of children on the spectrum (laugh) nowadays (I: yes) and I find that difficult to (.) I think well ok (.) *why* is that (I: um) now whether that is the case (.) that there are more children now or is it that we just didn't (.) *see* it then (I: yes) you know twenty years ago (I: mhm) I don't know um (.) what (.) my experience is from what I *know* (.) about in and ***only*** **the cases that I know** of so that I can speak about it (I: yes) is the (.) and it's going back to the parents thing is (.) there seems to be (.) some (.) problems in parenting (.) now whether that's because the child has ADHD (I: um) and the parents' responding (.) by you know (I: yes) by *over* (.) over indulging or over over compensating (.) or (.) is it that the way the child (.) the way the parents behaving toward the child is causing them (I: mhm) to behave in that way (I: yes) so I'm not sure I mean I would (.) my sort of feeling about it is that it's probably a a (.) sort of environmental problem (I: ok yes) rather than (.) biological (I: yes) I think (.) (I: ok) that is my (.) (I: yeah your view) but then I would have to see more in order to (.) but I have seen it a lot or maybe it's just that things that you (.) you see or hear you know (I: mhm) 'oh this child has ADHD' and you think well actually *no* the child (.) you know (I: yes) or from my point of view (I: mhm) *no* I don't think the child ADHD it's just (.) poor parenting (I: right) um you know and we have had a (.) couple of children in school who are I I don't know if they've been diagnosed ADHD (I: oh yes) but you know their parents have said 'oh yeah I think he's got that (.) ADHD' and it's basically just no parental control (I: right) you know (I: yes) but whether (.) they do as I said whether (.) which one comes first I can't say (I: right) but that would be my feeling (I: yes) is that it's more (.) now (.) that's not to say that I don't think there are children who *will* (.) have ADHD and there will (.) you know that it's (.) there um a (.) biological thing (.) (I: yes) I don't know I don't know enough about it but I think maybe there's more (.) there's *too many* children (I: oh) being diagnosed (I: ok) I'm not saying they don't have it (I: no) but I don't think it's necessarily (a) biological thing (laugh)

Extract 6

Teacher Interview 3: Head Teacher of Sunnyvale Primary

[This follows T3's earlier extract]

T: […] (personally) *I I* see it as more behavioural than medical (I: mhm) um (.) but I *do* feel that er (.) a lot of the children who are diagnosed with ADHD (.) have (.) been er (.) brought up in a certain way (.) and er (.) certain behaviour patterns are established at an early stage which are then very difficult to break (I: oh) I mean I don't I (.) you know I just don't know I'm not qualified to say whether that's the case in every (.) well I'm sure it's not (.) true in every case but em **you know in a a number of cases** I think children who are set to be (.) to have ADHD (.) you know that that would be my explanation for it (.) you know that they're not given clear boundaries and so on when they're children um (.) they're allowed to do pretty much whatever they want and so on and when then they come in a school environment where (.) that's not possible and then that that causes difficulties but by the time they've come to school you know they've had four or five years of em (I: right) behaving in a particular way and then they find it very difficult to adjust sometimes […] I've I've seen it er (.) er in two out of the three children I have here definitely (.) the other the other family I wouldn't say that was the case (I: mhm) necessarily (.) *although*(.) even there I think you there's sort of family factors […]

Extract 7

Teacher Interview 5: Class Teacher of Greenwood Primary

I: […] [asking T5 to talk about experiences of a pupil diagnosed with ADHD in her class]
T: […] **with *him*** I think a lot of it is (.) *learned behaviour* I had my doubts at first as to whether or not he was ADHD (I: oh yes) um (.) because he does have a brother (I: um hum) that has *certainly* been diagnosed with it and it causes *major* problems […] so the (.) wee boy I've got (.) I think he has learned a lot (I: oh) I think (.) (I: do you) after his behaviour (I: oh I see) and I just feel at this stage that you know getting him young in school (I: um hum) you know we're just trying to (.) undo that behaviour sort of thing
I: so do you see it as not necessarily as having this disorder or label ADHD (.) but rather from observing his brother
T: I think he he's learned *a lot* now I'm not saying he *hasn't* got ADHD (I: yeah uh huh) you know cos that's (stands almost a) a year now I've had him (I: oh) and I think (.) certainly (.) no I think he will (get labelled with) a diagnosis but (.) er you know I'll stick to my guns I think and (and I'll say) he's learned it (I: oh yes) cos there's a younger brother and (.) you know I've I've observed him (I: oh yes) and (.) I think he's going along the same ranks (.) and I'm I'm pretty sure a lot of it is learned (I: mhm) I really do (I: yes) I might be wrong (I: um) you know um (.) I don't know (.)

Extract 8

Teacher Interview 8: Class Teacher of Newville Primary

[This extract appears at the end of T8's interview when another teacher T9, comes into the interview room to be interviewed and T8's interview has to end due to time restraints. T9 offers her own responses to some of the questions].

I : **and how do you think a child comes to have ADHD**
T: ooh there's a question (laugh)
(T9: (inaudible))
I: (laugh) yes just in your opinion
T: em (.) I have no idea I don't think (I: um) how a child comes to be diagnosed with ADHD (laughs) () (I: (laughs))
T9:= I've got an answer for you that you might find quite interesting
T: =well (.) *I* was gonna come back to something I said earlier
I: yeah
T: perhaps **some of the cases** are perhaps not ADHD (I: um hum) but perhaps lack of (.) em rules boundaries parental guidance (.) perhaps going through a family (.) you know if a parent hasn't had the support when they were younger (I: yes) then I think there are many social issues that also go (.) around ADHD […]

Teacher empowerment negotiated through expertise and knowledge: The 'cases I know'

In extracts 5-8 above, there is a clear ideological dilemma for teachers in relation to the opposing subject positions from the repertoires. Such contradictory subject positions centre on a lack of agency in relation to children's difficulty, versus an empowered position. The extracts highlight the workings of both the ADHD repertoire and the Not ADHD repertoire. While there is much that could be analysed in these extracts, this analytic section focuses on the discursive features in relation to the two repertoires and the explication of the ideological dilemma that they entail. These extracts concern the origins of ADHD or difficult behaviour (i.e. *How do you think a child comes to have ADHD)* which was posed directly by the interviewer in extracts 5 and 8, or which appeared indirectly in extracts 6 and 7. What is noteworthy in these extracts is how the Not ADHD repertoire achieves dominance in relation to the ADHD repertoire. The discursive features of the repertoires will be examined in turn. These are lengthier extracts but they provide a fertile means of examining the workings of the repertoires in order to examine how this ideological dilemma was resolved.

There is a clear tension in the above extracts in terms of the ideological dilemma which is articulated in extract 5 with: “I don’t know I’m very much in two minds about it” (line 5), in response to the interviewer’s question about the how a child “comes to be like that” (line 1). This indicates the presence of a dilemma which is elaborated later in this extract in lines 12-16: “there seems to be (.) some (.) problems in parenting (.) now whether that’s because the child has ADHD (I: um) and the parents’ responding (.) by you know (I: yes) by *over* (.) over indulging or over over compensating (.) or (.) is it that the way the child (.) the way the parents behaving toward the child is causing them (I: mhm) to behave in that way”. From this there are two possibilities made available in the talk: either the child has ADHD and the parent is responding to that condition, or the way that the parents are behaving is causing the child to behave in a particular way (i.e. Not ADHD). In lines 16-18 of this extract the dilemma is further specified here with: “so I’m not sure I mean I would (.) my sort of feeling about it is that it’s probably a a (.) sort of environmental problem (I: ok yes) rather than (.) biological”. Here the deputy head orients to an “environmental” problem as opposed to a “biological” problem. In extract 6, the head makes a similar distinction with: “(*personally*) I I see it as more behavioural than medical” (line 1). In extract 7, the class teacher orients to the ideological dilemma with talk about “doubts”: “with him I think a lot of it is (.) *learned behaviour* I had my doubts at first as to whether or not he was ADHD” (lines 3-4). Here there is a distinction drawn between “learned behaviour” and “ADHD” with “doubts” indicating an orientation towards the behavioural. In extract 8, such doubts are exhibited with: “ooh there’s a question (laugh)” (line 2) and followed later with: “perhaps some of the cases are perhaps not ADHD” (line 10). Hence, the above extracts displayed similar orientations to the distinction and dilemma between ADHD as a condition versus Not ADHD (i.e. behavioural difficulties).

In addition to the above, there is a similar distinction relating to this dilemma whereby medical knowledge is contrasted with educational practice and experience. This is evident in all extracts but will be discussed in detail by reference to extract 5 as an example whereby the deputy head discusses such educational practice with: “but I have seen it a lot or maybe it’s just that things that you (.) you see or you hear you know (I: mhm) ‘oh this child has ADHD’ and you think well actually *no* the child (.) you know (I: yes) or from my point of view (I: mhm) *no* I don’t think the child [has] ADHD it’s just (.) poor parenting” (lines 20-22). In these lines educational practice is contrasted with medical knowledge about ADHD as held by parents, to highlight the

child's difficulties as due to "poor parenting". This is further reiterated in lines 23-25: "and we have had a (.) couple of children in school who are I I don't know if they've been diagnosed ADHD (I: oh yes) but you know their parents have said 'oh yeah I think he's got that (.) ADHD' and it's basically just no parental control". In this turn the deputy orients again to the contrast between medical knowledge and ADHD claims as held by parents, with experiential knowledge and practice in school which disputes this in order to undermine these claims. In lines 27-29 there is a further orientation to such medical knowledge with: "now (.) that's not to say that I don't think there are children who *will* (.) have ADHD and there will (.) you know that it's (.) there um a biological thing". This functions as a concessionary orientation to such medical knowledge claims about ADHD, while at the same time works to undermine such orientations by the explication of educational practices in which alternative experiences of Not ADHD are heard. The workings of the repertoires will be further considered in these extracts in order to explore how this dilemma was resolved in talk.

There are a number of associated characteristics with the use of the repertoires here. The first general point to note is that the origins of children's difficulties are oriented to as problematic. This was best exemplified in relation to a direct question by the interview, as in extracts 5 and 8 for example. In extract 5 this was particularly noticeable because after the interviewer poses the question: *and how do you think a child comes to be like that [ADHD]*, there was great hesitancy, qualification and deliberation in this extract before an account was offered which is taken as evidence that this was oriented to as troublesome or that the account to follow was 'dis-preferred' (Pomerantz, 1984a). This was characterised by seven lines of such hesitancy (e.g. lines 3-8 are characterised by pauses and hesitancy and the use of "well" signals that the utterance to follow is problematic). In extract 8, this is also evident with: "ooh there's a question" (line 2) followed by a laugh which could be taken to signal the problematic nature of the request (Jefferson, 1984). In both extract 5 (line 4) and 8 (line 4) the interviewer is also required to reformulate the question in order to probe this questioning (Pomerantz, 1984b). Like in extract 5, the class teacher displays great difficulty and reluctance in putting forward an account, as seen in the pause and the emphatic and emphasised: "I have no idea I don't think (I: um) *how a child comes to be diagnosed with ADHD* (laughs)"(line 5-6). Extract 5's: "I don't know I'm very much in two minds about it" (line 5) and extract 8's eventual: "I have no idea I don't think (I: um) how a child comes to be diagnosed

with ADHD (laughs)" (line 5) orient to the ADHD repertoire as tied to a lack of knowledge here as associated with "I don't know" formulations.

In addition to the hesitancy and orientation to the interviewer's request as problematic, there is evidence of great discursive work displayed in these extracts in order to articulate the Not ADHD repertoire in all extracts. This is evident in extract 5 with orientation to this repertoire with: "and it's going back to the parents thing is (.) there seems to be (.) some problems in parenting" (line 11-12), and later in the sequence: "my sort of feeling it is that it's probably a a (.) sort of environmental problem (I: ok yes) rather than (.) biological" (line 16-17). The Not ADHD repertoire is worked up here as related to parenting issues which appear as an alternative explanation to ADHD. In relation to extract 6, likewise, the head teacher can be seen to be orienting to the Not ADHD repertoire with the turn of: "personally I I see it as more behavioural than medical" (line1). This is then expanded with: "but I do feel that er (.) a lot of the children who are diagnosed with ADHD (.) have been er (.) brought up in a certain way (.) and er (.) certain behaviour patterns are established at an early stage which are then very difficult to break" (lines 1-4). Like extracts 5 and 8 as described above, these utterances are characterised by hesitancy and deliberation (i.e. pauses, the use of "er", and the use of non-specific adjectives – "a certain way" and "certain behaviour patterns" – as opposed to a more explicit description). Like extract 5, a Not ADHD repertoire is deployed in order to account for children's behaviour as originating in behavioural aspects rather than medical. In extract 7, the class teacher also orients to the Not ADHD repertoire when describing a pupil diagnosed with ADHD in her class: "with *him* I think a lot of it is (.) *learned behaviour* I had my doubts at first as to whether or not he was ADHD… (lines 3-4)". Here the introduction of "doubts" offers an alignment towards the Not ADHD repertoire where the behaviour is seen as learned as opposed to a medical condition. Extract 8 is interesting because the class teacher's initial display of reluctance to put forward an account (as seen in the earlier formulation of: "I have no idea") gives way with the learning support teacher's entrance into the room and apparent readiness to offer an account with: "I've got an answer for you that you might find quite interesting" (line 7). Within the interview setting this is interesting because rhetorically the interviewer would be expected to abandon this line of enquiry in the face of the initial "I have no idea". To persist with this questioning in the face of vehement uncertainty would be considered unreasonable. However, the significance of the learning support teacher's entrance and orientation to readiness,

in relation to the question, appears in this context to facilitate further turns by the class teacher. It is thus significant that the class teacher chooses to take up the next turn instead of allowing the learning support teacher to continue with her own ready account. The eventual: “well (.) I was gonna come back to something I said earlier” (line 8) signals an account to follow with: “perhaps some of the cases are perhaps not ADHD (I: mhm) but perhaps lack of (.) em rules boundaries parental guidance” (line 10-11) with clear evidence of the Not ADHD repertoire. Again the problematic nature of this repertoire is worked up as seen in the repetition of: “perhaps” as a qualifier. Thus the Not ADHD repertoire appears in these extracts and requires great discursive work in order to specify this repertoire to: “poor parenting” (extract 5); “behaviour patterns” (extract 6); “learned behaviour” (extract 7) and “lack of rules/boundaries/parental guidance” (extract 8).

A further discursive feature exhibited is the dichotomy or contrast built into the accounts. This was previously noted in the previous section and the data extracts 1-4 but it appears here as well. In extract 5, the deputy head elaborates on the dichotomy in the repertoires on various occasions such as: “you see or hear you know (I:mhm) ‘oh this child has ADHD’ and you think well actually *no* the child (.) you know (I: yes) or from my point of view (I:um) *no* I don’t think the child (has) ADHD it’s just (.) poor parenting” (line 20-22). The distinction is made between ADHD as opposed to “poor parenting” and it’s clear that the deputy can be heard to be challenging the use of ADHD for something that has as its origins, mere “poor parenting”. This is reiterated further with: “um you know and we have had a (.) couple of children in school who are I I don’t know if they’ve been diagnosed ADHD (I: oh yes) but you know their parents have said ‘oh yeah I think he’s got that (.) ADHD’ and it’s basically just no parental control…” (line 22-25).

The ADHD repertoire features in these extracts largely as a contrast to the Not ADHD repertoire: “now (.) that’s not to say that I don’t think there are children who will (.) have ADHD and there *will* (.) you know that it’s (.) there um a (.) biological thing…” (extract 5, line 27-29); “I’m sure it’s not true in every case” (extract 6, line 6); “now I’m not saying he *hasn’t* got ADHD (I yeah) uh huh) you know…” (extract 7, line 12); and “some” of the cases (extract 8, line 10). Another characteristic of the ADHD repertoire from the above is that it appears as abstract or theoretical possibility. The orientation to the abstract possibility of the ADHD repertoire is achieved because of the lack of elaboration and discussion here, which is in contrast to the above Not ADHD repertoire. Tied to its properties as an abstract

contrast, the ADHD repertoire was also associated with a lack of knowledge, as seen directly in: “I don’t know”. Now while the extracts in general may be characterised by hesitancy in view of such orientations to non-ADHD work, the function of associations with the ADHD repertoire to a lack of knowledge are significant. For example: In extract 5, the deputy follows the orientation and reference to the ADHD repertoire with: “I don’t know I don’t know enough about it” (lines 29-30). In extract 6, the head teacher follows his orientation to the Not ADHD repertoire and the interviewer’s “oh” with: “I mean I don’t I (.) you know I just don’t know I’m not qualified to say whether that’s the case in every (.) well I’m sure it’s not (.) true in every case…” (lines 4-6). Also, in extract 8, the class teacher signals an initial utterance of: “em (.) I have no idea I don’t think (I: um) how a child comes to be diagnosed with ADHD (laughs)” (line 5-6). This serves to link a lack of knowledge with the ADHD repertoire, and further highlights its abstract and theoretical properties. Thus in these associations the subject position of the non-expert teacher is invoked with a lack of knowledge. The use of “I don’t know” and similar formulations in these extracts can also be considered due to its rhetorical functions. Previous discursive work has associated “I don’t know” formulations with prefacing sensitive topics or accounts of complaints or disinterest (e.g. Pomerantz, 1984a; Potter, 1997; Edwards, 2005; Wooffitt, 2005). In this context, the “I don’t know” formulation, works in order to signal the teachers’ disinterest in the sensitive or contested topic of ADHD. The accounts work to demonstrate that these are not clearly formulated accounts by prejudiced teachers who are unreasonable in their attempts to hold parents accountable for the difficulties. Instead, the teacher’s account is heard as a dispassionate, distanced account which establishes the speakers’ identity as someone rational and reasonable and without vested interests, and therefore credible. This is particularly relevant, it is argued, within this context whereby accounts of Not ADHD are tied to critical explanations about parenting. This works to avoid the negative identity of the irrationally biased teacher.

Finally, in terms of the contrast that was worked up with the ADHD repertoire and its association to a lack of knowledge, there is evidence of the simultaneous orientation to the Not ADHD repertoire as associated with teacher knowledge and expertise which achieves dominance in these extracts. The ideological dilemma for teacher subject positions rests on the clear association in these extracts of the Not ADHD repertoire with concrete, experiential knowledge, as opposed to an abstract, distanced entity in the ADHD repertoire. This will be explored further. In extract 5,

the deputy head prefaces the Not ADHD repertoire with: “what (.) my experience is from what I know (.) about in and only the cases that I know of so I can speak about it….” (line 9-11) in order to tie the Not ADHD repertoire to experiential knowledge. This orientation is achieved further with the later orientation to experiential knowledge as seen in, for example: “…but I have seen it a lot or maybe it’s just the things that you see or you hear…” (lines 19-20). In extract 6 likewise, the head follows the orientation to the Not ADHD (and behavioural issues) with his assertion that: “… but em you know in a number of cases…” (lines 6-7) . Later he follows his description of the Not ADHD repertoire with a turn to a concrete example: “I’ve I’ve seen it er (.) er in two out of the three I have here definitely (.) the other the other family I wouldn’t say that was the case (I: um hum) necessarily (.) although (.) even there I think you there’s sort of family factors…” (lines 13-16). What is significant here is that he is able to orient to his own experiential “cases” in which the Not ADHD was applicable and that ultimately the Not ADHD repertoire is able to account for the behaviour of *all* three cases. In extract 7, the classroom teacher cannot and does not orient to generalised “cases” as in the other extracts as this is her first instance of a pupil diagnosed with ADHD. Her grounds to speak, therefore, about the Not ADHD repertoire rest with a single pupil as seen in: “with *him* (line 3)”. Thus the class teacher can only talk from the basis of a particular pupil. From this orientation to the particular, it is clear that “learned behaviour” (line 3) is largely used to account for the pupil’s behaviour. The class teacher, unlike the other extracts, does not have reference to other “cases”, however there is a similar orientation to alternative areas of expertise and knowledge in relation to the pupil as seen in the significance of: “because he does have a brother…” (line 4) and later: “ cos there’s a younger brother and (.) you know I’ve I’ve observed him (I: oh yes) and (.) I think he’s going along the same ranks…” (lines 15-17). The effect works in the same way as the other extracts because experiential knowledge is linked to instances of the Not ADHD repertoire. Finally in extract 8, the class teacher also orients to the notion of experiential knowledge with: “perhaps some of the cases are perhaps not ADHD” (line 10) in which she ties the Not ADHD repertoire to a discussion of her own experiences and views.

Thus, in sum, teachers oriented to the inherent ideological dilemma in terms of empowerment, by the association of the Not ADHD repertoire with experiential knowledge and expertise. This involved the rhetorical device of the: ‘*cases I know’*. This was evident in relation to the extracts and the highlighted: “cases that I know”

(extract 5); “you know in a number of cases” (extract 6); “with *him*” (extract 7) and “some of the cases” (extract 8) which is a direct orientation to teacher experiences of Not ADHD. It was clear that the Not ADHD repertoire appeared dominant in these accounts and oriented to alternative explanations as: “poor parenting”, “behaviour patterns”, “learned behaviour” and “lack of rules/boundaries/parental guidance”. This repertoire, as elucidated above, was given great discursive work in these extracts and set up in direct contrast to the ADHD repertoire.

Summary

In sum, teacher talk about the origins of ADHD and children’s difficult behaviour were clearly sensitive or troublesome. Like in the previous section, there was evidence that teachers’ accounts simultaneously maintained the Not ADHD and ADHD repertoires which were outlined earlier. In doing so, it was clear that the Not ADHD achieved greater significance in these extracts because of the detail and elaboration achieved in the extracts. The discursive features associated with the ADHD repertoire here was that it was characterised as an abstract entity and tied to associations with a lack of knowledge as seen in: “I don’t know” formulations. The Not ADHD repertoire, by contrast, was associated with parenting explanations as detailed above. A distinctive feature was that it was tied to the contrary position of experiential knowledge as epitomised in the turn to the rhetorical device of the: ‘*cases I know’*. This was demonstrated in talk about: “only the cases that I know” (extract 5); “you know in a number of cases” (extract 6); “with *him*” (extract 7) and “some of the cases” (extract 8). In sum, it is argued that it was through recourse to experiential knowledge therefore that teachers were able to negotiate and achieve expertise and empowerment for their own experiential knowledge over the contrary position of being non-experts in the face a medical condition as ADHD. It was significant here that talk about such ‘cases’ were all instances of Not ADHD.

The Not ADHD repertoire and accounts of (Mis)diagnosis and (Mis)treatment

The earlier sections highlighted how teachers oriented to competing repertoires about children’s behaviour as the ADHD repertoire and the Not ADHD repertoire with contradictory subject positions entailed about teacher management and empowerment. It was highlighted that teachers’ accounts were oriented to

accomplishing the Not ADHD repertoire and teacher empowerment through associations with experiential knowledge through talk about the: '*cases I know*'. Thus the Not ADHD repertoire achieved prominence in these accounts. It is argued further that an orientation to the Not ADHD repertoire in the accounts meant that further talk accomplishing non-ADHD discursive work was hearable through talk about misdiagnosis and medication concerns. This occurred as alternative or counter-positions to medical ADHD explanations of *diagnosis* and *treatment*. The following data is considered in relation to these patterns.

Extract 9

Teacher Interview 4: Head Teacher of Greenwood Primary

I: […] what does ADHD mean to you
T: er a huge range of em different behaviours (.) from the ADHD spectrum that we've had in school um I think (.) one of the biggest things for us as teachers is (.) the medication side of things […] cos you'll find amongst us teachers most of us are concerned about the amount (.) of medication often we feel without reason […] a lot of times we have (.) the Conner's rating scale sent to us and we have very few concerns on (that compared) to that at home (.) it's a it's a difficult one but most schools have great concerns just now (.) about the amount of Ritalin particularly in [local area]
I: yes (.) it does seem to be a lot in [local area]
T: and I think the most concerning thing is when we're given a (graph) to fill in the scale (.) it doesn't seem to matter what we say (I: ah right) whether or not the Ritalin is prescribed […] I now actually send in a cover letter whenever I fill one in (I: mhm) it goes (.) a letter goes with it with a fuller explanation of the child in class and how we find the child (I: yes) because the guidelines here are that (.) children have to display the symptoms if you like of ADHD in more than one context (I: yes) it seems to be (.) only the home context that counts (laugh) (I: right) so it is worrying (.) and then we've seen a few children who are losing their appetite (.) losing their concentration in a different sense (.) they're not with us […] it's a very cynical outlook but our school community doctor agrees (laughs) I don't know if you've heard this one before but you know the disability allowance (I: oh yes) which is automatically given to children who are diagnosed with ADHD and on Ritalin (I: right) and there's a (.) you know (.) it does seem to have an influence on whether children are ADHD or not (laughs)
I: yes (.) so do you think that's an issue for parents then
T: it's an issue (I: mhm) for some parents not for all you know I'm not saying =
I: =of course
T: but there's certain instances where we've been asked to fill in a Conner's rating scale for children in a class (where they've been absolutely perfect) (I: oh I see) however (.) in one instance when the covering letter went in it didn't actually happen but it does happen a lot and it is a worry on something that's as strong a drug as Ritalin um and from what I've read (.) about the effects it's having the long term effects possible (.) coming back from America just now it does worry me that young children are on such strong medication (I: yes) and sometimes you feel it's really about behaviour and the *management* (.) rather than a (.) a syndrome

Extract 10

Teacher Interview 7: Deputy Head of Newville Primary

I: […] are there any issues or concern or worries that you have about this issue
T: no I would just say (.) just what I've said (I: mhm) it really concerns me about the amount of drugs that seem to be (.) of medication not drugs (.) the amount of medication that seems to (be) given to children at a very young age (I: yeah) now that *really* worries me and medication that maybe we don't know (.) what's it's going to do to them
I: like the long term
T: yeah um (.) and where you know if there's misdiagnosis (I: yes) what you know happens to a child (I: yes) if if they're taking these things and also that (.) and it may (.) now I don't know so and I can't say this with any authority at all but (.) the (.) it it is (.) if parents are believing that their child does have ADHD (I: mhm) and maybe they don't now I don't know how the medical profession (.) respond to that but (.) you know it's just like (.) what if it is misdiagnosed and what if it's like (.) yes well maybe the child does have ADHD but what if there's another way round it by maybe (.) to do with parenting that we could (.) (I: mhm) do something (.) go along those lines (I: right) could it be and I mean because I don't know enough about it (I: mhm) maybe it's not like that it's just my feeling (I: yeah) but um (.)
I: so in that are you saying in that in that (.) if a child is labelled ADHD then we kind of miss the other things like (T: yes) with the parenting or
T: yes yes it's like it's (.) back to the thing 'well I can't do anything about it it's not my fault it's my syndrome' […] and I mean I've seen it in (.) um in secondary schools […] I've seen kids sitting around (I: mhm) tables and going 'oh well and what one have you got' 'oh well I've got um (.) this and that' (.) you know and you think *oh my god what's going on here* you know (I: yes) these are kids (.) teenage kids and (.) the (.) they don't have to take responsibility cos it's not them it's their syndrome

Although it is conceded that there is potentially much that could be analysed in the above lengthy extracts, the analysis is focused on teacher accounts for ADHD explanations as competing versions to the Not ADHD repertoire. How teacher accounts are able to offer robust counter-positions and accomplish the Not ADHD repertoire in the face of ADHD explanations is an important aspect for analysis.

With regards to extracts 9 and 10 then, it is clear that in the first instance there is a clear orientation to the ADHD repertoire as a medical explanation for children's difficulties and as defined by diagnosis and treatment. What is noticeable about this repertoire is that it appears as largely attributed to accounts by others. These others include parents, the medical profession and health policy guidelines for ADHD. It is absent from teacher/schools concerns here. In the analysis of the previous sections, the ADHD repertoire in teacher accounts was previously associated with a passive subject position for agency and knowledge. Here this

passive subject position is invoked as well. The subject position of a passive response is hearable in a number of ways relating to being excluded as experts; concern or worry; lack of knowledge and disempowerment. A position of exclusion as experts is evidenced in extract 9 with the head's: "it doesn't seem to matter what we say" (line 12) in relation to the completion of a Conner's Rating Scale for assessment of possible diagnosis of ADHD. Further line 16-17's "it seems to be (.) only the home context that counts (laugh)" which works to set up a subject position for schools as excluded and disempowered in the face of talk about the diagnostic process. Extract 9's emphasis and repetition of "concern" (lines 5; 8; 11) and "worry" (lines 17; 30; 32) also implies a passive position - i.e. that of an outside passive observer. Similarly in extract 10, the deputy head implicates the lack of agency with similar orientations to the passive observer and reference to: "concerns" (line 2) and "*really* worries me" (line 5). While the deputy head teacher is orienting to the interviewer's question (*are there any issues or concern or worries that you have about this issue*) and can be seen to be echoing "concerns" and "worries", the deputy here elaborates and returns to previous talk about this topic (i.e. seen in "just what I've said….", line 2). In addition to the distant passive observer who is concerned, the deputy also makes reference here to her lack of knowledge regarding ADHD generally with: "now I don't know so and I can't say this with any authority at all" in line 10 and the conclusion of this turn with: "I don't know enough about it (I: mhm) maybe it's not like that it's just my feeling "in lines 16-17. Finally there is a further orientation of the lack of agency invoked in reference to line 20's: "it's like it's (.) back to the thing 'well I can't do anything about it it's not my fault it's my syndrome'". (This reference reoccurs here and had appeared prior to this elsewhere in the interview). The implication of the reference here is that not only do the children or teenagers not "have to take responsibility cos it's not them it's their syndrome" (line 25) but so too are *teachers* positioned as unable to hold children accountable for behaviour and so powerless to enforce discipline. This echoes extract 9's: "and sometimes you feel it's really about behaviour and the management (.) rather than a (.) a syndrome" (lines 33-34) where, similarly to extract 10, the notion of a "syndrome" appears against the teacher's potential to act and manage behaviour.

The contrary Not ADHD repertoire was linked in earlier sections with the teacher subject position of empowerment and agency. It is clear that it reoccurs in these extracts and is evidenced primarily through the similar rhetorical device of the

'*cases I know*' in order to link teacher agency and knowledge to non-ADHD explanations. Evidence that teacher accounts are orienting to and making use of the '*cases I know*' device is found in these extracts in reference to: "we've seen a few children" (extract 9, lines 17-18) and "it does happen a lot" (extract 9, line 30); "I've seen it in" (extract 10, line 21) and "I've seen kids sitting around" (extract 10, line 22). Thus these extracts employ experiential knowledge again in order to accomplish not ADHD talk. Tied to these '*cases I know*' and teacher expertise and agency, the extracts work to accomplish two specific knowledge claims which are made relevant here and which function to account for Not ADHD claims. These knowledge claims can be seen to be the inverse of ADHD knowledge claims by others which rest on the medical terms of *diagnosis* and *treatment*. These knowledge claims orient to accounts of *misdiagnosis* and *mistreatment* and are explored further.

Thus the first knowledge claim that is relevant relates to issues of *misdiagnosis*. If ADHD can occur as a medical explanation with the subject position of the medical expert, then the contrary position is also made available through the possibility of misdiagnosis through medical incompetence or limits. This is evident explicitly in lines 11-17 of extract 9 where the head teacher is accounting for the practice of medical assessment for ADHD. In this extract medical failings are implicated: "because the guidelines here are that (.) children have to display the symptoms if you like of ADHD in more than one context (I :yes) it seems to be only the home context that counts (laugh)" (lines15-17). What is significant from this turn is that medical practitioners can be heard to be contravening health policy guidelines for ADHD by their refusal to consider the school context, and by basing decisions on only one context (i.e. the home). It was argued above that this also implicated a passive position for the school in terms of agency, and it is clear that it has an additional function here in terms of implicating medical incompetence. What is also striking about this particular extract (and unlike some of the other accounts by teachers) is the head teacher's demonstration of knowledge about ADHD here as related to diagnoses of ADHD in order to achieve an account of misdiagnosis. The implication is that if a diagnosis is made, based on only one context, then that very diagnosis is suspect. In addition to medical incompetence, there is also the invocation of parental pressure on the diagnostic process: "it's a very cynical outlook but our school community doctor agrees (laughs) I don't know if you've heard this one before but you know the disability allowance that (I: oh yes) which is

automatically given to children who are diagnosed with ADHD and on Ritalin (I: right) and there's a (.) you know (.) it does seem to have an influence on whether children are ADHD or not (laughs)" (lines 19-23). This is a complex turn which can be heard as an account about troubles-telling (i.e. the appearance of the laugh in the account, Jefferson, 1984). Here the head teacher implicates parental pressure for Disability Living Allowance as a possible motivational influence in the diagnosis of their children as ADHD, thus influencing the medical professionals. Clearly the account works up its credibility by the orientation to the medical expert (the school community doctor's agreement) and the orientation to this as a generality and widespread: "I don't know if you've heard this one before" (line 20). As a widely known view then, this is less likely to be heard as "cynical". In extract 10 the deputy head also orients to misdiagnosis with: "and where you know if there's misdiagnosis" (line 9) and "what if it is like misdiagnosed" (line 14). Here the possibility of misdiagnosis is raised and made relevant. There is, like extract 9, an implication of the medical profession with: "if parents are believing that their child does have ADHD (I: mhm) and maybe they don't now I don't know how the medical profession (.) respond to that…" (lines 12-13). Here it's clear that the medical profession is constituted as under pressure from parents "believing that their child does have ADHD". The implication then is that such pressure may result in unfounded diagnosis, and this parallels extract 9 where the onus is shifted towards medical competency and parental motivations in the diagnostic process. This is relevant, it is argued, because if teachers' accounts can be undermined or heard as "cynical" then this is a sensitive issue.

If misdiagnosis is relevant from these accounts, then a similar account can be heard in terms of *mistreatment.* In extract 9, the first noteworthy aspect here is the head's constitution of a united body of teachers: "cos you'll find amongst us teachers most of us are concerned about the amount (.) of medication often we feel without reason" (lines 4-5) and "most schools have great concerns just now (.) about the amount of Ritalin particularly in [local area]" (lines 7-9). Clearly the schools appear as united against the use of medication and this works to build up a credible widespread concern rather than appearing as dispositional (i.e. a "cynical" head teacher). Further accounts of problems to do with treatment by medications such as Ritalin are heard based on the widespread quantity of medications: "most of us are concerned about the amount (.) of medication often we feel without reason" (lines 4-5); "but most schools have great concerns just now (.) about the amount of Ritalin

particularly in [local area]" (lines 7-8). This also orients to questioning medical competence here. In addition to quantity, side effects are also oriented to in terms of the mistreatment account: "we've seen a few children who are losing their appetite (.) losing their concentration in a different sense (.) they're not with us" (lines 17-19). This draws attention to the harmful effects of the medications as seen in relation to some children. Finally the strength or potency of Ritalin is invoked along with problems highlighted with the long term effects with: "it's a worry on something that's as strong a drug as Ritalin um and from what I've read (.) about the effects it's having the long term effects possible (.) coming back from America just now it does worry me that young children are on such strong medication" (lines 30-33). The sheer potency of the medication and research implications about the long term effects in America are oriented to in order to further achieve an account for mistreatment. Reference to research from America here works to build credibility for the account as legitimate and works again to attend to the issue of the "cynical" teacher. Extract 10 works in a similar way. In line 2 the deputy returns to talk about the (previously invoked) issues with medication and which similarly invoke quantity, potency and long term effects with: "it really concerns me about the amount of drugs that seems to be (.) of medication not drugs (.) the amount of medication that seems to be given to children at a very young age" (lines 3-5), and: "now that *really* worries me and medication that maybe we don't know (.) what it's going to do to them" (lines 5-7). This builds a legitimate account for mistreatment by such medications and serves to implicate medical competency. Finally, constructions of knowledge claims to do with the Not ADHD repertoire as misdiagnosis and mistreatment, were clearly sensitive issues in these accounts where teacher accounts ran the risk of being seen as "cynical" and so undermined due to these dispositional aspects. Thus, it was evident that teacher accounts attended to this by reference to working up the concerns as widespread across schools and referring to other experts or research (as in extract 9) in order to attend to their own potential bias or stake and inoculation (e.g. Potter, 1996). This worked to counter the notion that teachers had an interest in undermining such medical explanations based on personal bias and irrationality.

Summary

In sum, teacher accounts for the Not ADHD repertoire built claims of misdiagnosis and mistreatment. This existed as a competing or counter-version for ADHD as a

medical explanation for children's difficulty. In such accounts for misdiagnosis, medical (in)competence and parental motivations were constituted as creating ADHD diagnoses for children's behaviour. Accounts of mistreatment served to highlight the harmful effects of medications like Ritalin for children (i.e. the quantity, potency, side effects and long term effects). It is argued that accounts of misdiagnosis and mistreatment similarly worked to position parental motivations and medical competency in relation to children's difficulties as accountable. This positioning necessarily entailed a shift away from teacher accountability in this area. Thus accounts of misdiagnosis and mistreatment, as claims associated with the Not ADHD repertoire, were also associated with a passive subject position for teachers in terms of their own exclusion, worry and concern, lack of expert knowledge and ability to act. Although constituting children's difficulties as behavioural rather than as a "syndrome" in the Not ADHD repertoire worked to position teacher empowerment for management, it was ultimately limited. This temporal construction for subject positioning was limited because in the face of such claims of misdiagnosis and mistreatment, external responsibility was positioned for parents, medical professionals and health guidelines. A construction of the failings by parents and the medical profession also worked to position the school as focused on the interests of the child.

Conclusion

This chapter has analysed teacher accounts of children's difficulties and ADHD from semi-structured interviews with teachers from schools in an area of Scotland. Using Edley's (2001) framework as a way into the data, the analysis highlighted how teachers deployed the contradictory ADHD repertoire and the Not ADHD repertoire when ADHD was introduced as a topic by the interviewer. In the ADHD repertoire children's difficulties were constituted as a medical condition while the Not ADHD repertoire the difficulties were due to temporal behavioural difficulties. Teachers made use of a common rhetorical device in order to attend to empowerment and management of such behaviour in the classroom. Despite diagnoses of ADHD, teachers' clearly oriented to their own experiential knowledge to account for child's difficulties as Not ADHD. While they did orient to the ADHD repertoire, they did so as an abstract entity that was divorced from their experiences through the 'cases I know' device. Teachers were able to offer robust and sophisticated explanations for ADHD as instances of misdiagnosis and mistreatment which implicated medical

competence and parental motivations in such diagnoses rather than teacher ignorance. Teachers were able to display in their accounts elaborate accounts about medication effects and the controversies surrounding ADHD. Thus teachers had robust means of accounting for children's difficulties in the face of ADHD talk and emphasises that portrayals of teachers as merely ignorant about ADHD and requiring knowledge and information by such ADHD proponents, may be simplistic. Finally, accounts which produced teacher expertise were necessary in order to achieve agency in the area of children's behaviour where medical explanations as ADHD undermined such expertise. However, ultimately such accounts of misdiagnosis and mistreatment also produced a passive position for teachers, in the face of such influential actors as parents and medical professionals.

Chapter 8: Analysis of the Discursive Positioning of Parents and Teachers in talk about ADHD

Introduction

This chapter consists of an analysis of both parent and teacher subject positions in relation to talk about ADHD and in light of chapters 6 and 7. The previous chapters considered parent and teacher talk about their child's difficulties from Edley's (2001) analytic framework for critical discursive psychology. Such analysis focused on the interpretive repertoire, subject positions and the ideological dilemma deployed in talk about this topic. The present chapter seeks to extend these analytic claims by building from the main findings from the previous analysis and to offer further analysis of these findings both in relation to the empirical data and the wider context, in keeping with a critical discursive psychological approach. The chapter seeks to draw attention to the discursive positioning available for parents and teachers in talk about ADHD and draws on wider discourses surrounding ADHD. The chapter is divided into two sections and section one considers the findings from the parent analysis. In this section, the contextual use of the biological and environmental repertoires are considered; the 'good parent' device is examined further in relation to extracts by fathers; ADHD talk in relation to disease metaphors are explored; finally, a negative case analysis of parental talk about medication is presented for its implications for the wider analysis. In section two, the findings from the teacher analysis are further considered. In this section, the ADHD repertoire and Not ADHD repertoires are considered in relation to the use of semi-structured interviews; further elaboration of teachers' constructions of difficulties are specified; additional analysis of the role of the teacher in ADHD is examined; and finally, teacher constructions of ADHD are contrasted with current educational guidelines and health policy for ADHD.

Findings from the Parent Analysis

There were a number of key findings in relation to the parental analysis. The analysis highlighted the culturally available interpretive repertoires deployed by parents in talk about their child's difficulties. Parents used a Biological repertoire and an Environmental repertoire in which to account for the child's difficulties. Talk was

organised to attend to the moral accountability and the character of the parents and hence oriented toward the 'good parent'. The analysis highlighted how parents were able to persist with such biological explanations in the face of widespread dismissal of those views by others such as schools and families. Parental talk used medical expertise and specialist talk about ADHD in order to undermine competing views and relied on the 'out there' analogy with cancer to emphasise knowledge dissemination about this controversial topic. Treatment choices about medication were examined in talk about Ritalin to highlight parental positioning in relation to such medication. These findings are further considered below in relation to the data and the broader context.

Parental talk and the Biopsychosocial Model in ADHD

The analysis highlighted that parental talk attended, at least in research interviews, to issues of moral adequacy and accountability in talk about their child's difficulties. Accounts of moral adequacy have been found more generally for parents of children with a range of other health conditions as highlighted above (e.g. Baruch, 1981). That parents made use of a 'good parent' rhetorical device was argued above as significant for ADHD talk. What was further significant, however, was the parental deployment of a Biological repertoire and an Environmental repertoire to account for their child's difficulties in the first place. The availability of these repertoires, it is argued, is largely in keeping with a biopsychosocial model for ADHD which was outlined earlier (chapter 2) where a multiplicity of factors contributed to the child's condition as ADHD. Thus, in relation to this biopsychosocial model, parental talk demonstrated the use of the Biological and Environmental repertoire as distinct and opposing ways of accounting for the child's difficulties. What is noteworthy is that the use of such repertoires in this manner meant that a biopsychosocial model emerged in these accounts as fragmentary and opposing 'factors' rather than as an integrated or holistic explanation for the child's difficulties. This will be examined further in relation to the following extracts, two of which are reproduced from chapter 6.

Extract 6; Chapter 6:

Parent Interview 2: Mrs Roberts of Ian

I: Tell me about your child
P:[…] I feel an important thing about em before having Ian is I was really anxious (I: um hum) all through my pregnancy […] and I don't know (.) I sometimes look back on it and wonder because of all the anxiety and stress (.) you know havin' a child that I wasn't prepared (.) for (I: mhm) () how's my husband gonnae react , how's my kids gonnae react […] so I don't know if that maybe had somethin' to do with the way Ian is

In extract 6 of the parent analysis, for example, Mrs Robert's use of the Environmental repertoire was highlighted in section one of the analysis in chapter 6. In this extract Mrs Roberts oriented to maternal stress and anxiety to account for her child's difficulties in lines 3-4: "I sometimes look back on it and wonder because of all the anxiety and stress…" and in lines 6-7: "…if that maybe had somethin' to do with the way Ian is". The notion that maternal stress and smoking, for example, is associated with later ADHD symptomatology has been supported in recent research (e.g. Rodriguez and Bohlin, 2005). These environmental aspects are seen to contribute to ADHD causality and allow incorporation into a biopsychosocial model for ADHD. However, in this account it is argued that the contribution of the maternal stress and anxiety is largely constructed as a discrete explanation (which elsewhere gives way to a biological explanation). The emphasis on "somethin' to do with" was argued in the analysis in chapter 6 to refer to a complex, indirect and unclear pathway of causality. This has the result of implicating parental actions into the causal pathway for ADHD and the child's difficulties. Thus the analysis highlights how it is that biopsychosocial explanations for children's difficulties were socially produced in these parental accounts and demonstrates the fragmented and opposing nature of the accounts which occurred, rather than producing an integrated model to account for the child's difficulties. This is further exemplified if we consider an earlier extract from the same narrative which occurred when the interviewer asked Mrs Roberts to define what ADHD meant to her; despite some initial difficulty, the following account was produced:

Extract 1

Parent Interview 2: Mrs Roberts of Ian

I: so what do you think it means to have ADHD
P: huh (.) I dinnae I honestly think (.) do you mean as in – I think that there's a (I: = to you) to me I think that there's an imbalance in the brain somewhere (I: ok) I think there's a problem for me in the brain and that that that that you you want to keep goin' and you're needing somethin' to calm you down (I: oh) it's no anything to do with wha' you eat because (.) years ago I ate completely different from ma mum and dad (I: mhm) because they're on about additives and stuff like tha' and dinnae get me wrong they do contribute […a few lines omitted…] they're on about organic I was actually reading and I thought well maybe I should try it cos you try everythin' when you've got a problem (I: oh) you try and solve it and I thought well maybe if I start growing my own vegetables and everythin' the next thing I went wait a minute (.) you cannae do that because if it's already in the ground and it's at the fields (I: mhm) so if its next door its travelled up there if its travelled there its next door you know what I mean I'm thinkin' so what's the point of organic yeah you might not have all the pesticides but the problem might still be there because its in the ground

In the earlier account it is clear that Mrs Roberts has at her disposal a Biological repertoire which is able to be offered to describe ADHD with: "to me I think that there's an imbalance in the brain somewhere" (line 3). This explanation is consistent with the dopamine deficiency explanation for ADHD. Lines 4-5 are revealing in terms of the subject position available from this explanation: "I think there's a problem for me in the brain and that that that that you you want to keep goin' and you're needing somethin' to calm you down". Thus the subject position available is one where medical intervention is required (i.e. "needing somethin' to calm you down") which can be heard as Ritalin. In the sequence that follows, Mrs Roberts can be seen to be speculating on an alternative and contrasting explanation with: "it's no anything to do with wha' you eat…" in line 6. This appears as a more speculative and troublesome explanation to reconcile in the narrative in the lines that follow with: "because they're on about additives and stuff like tha' and dinnae get me wrong they do contribute…" (lines 7-8). This environmental explanation involving diet/food additives appears problematic to reconcile as "it's no anything to do with wha' you eat" (line 5) appears to contradict "they do contribute" (line 8) to account for the role of food additives in ADHD. A few lines were omitted here and then Mrs Roberts can be seen to be orienting to turn to organic food with: "they're on about organic" (line 8). In stark contrast to the earlier biological explanation, the subject position available from the use of this environmental repertoire involving organic food is heard with: "I was actually reading and I thought well maybe I should try it cos you

try everythin' when you've got a problem (I: oh) you try and solve it" (lines 8-10). Unlike the previous biological explanation where medical intervention is required for her child (i.e. "you're needing somethin' to calm you down"), in this environmental explanation involving diet and organic food, Mrs Roberts is required to negotiate her own role in providing an adequate diet for her child. Clearly food is an area under parental (maternal) control and responsibility and this is evident in talk about "I" as seen in: "I was actually reading and I thought well maybe I should try it cos you try everything when you've got a problem". Here there is an orientation to parental active efforts to provide a good diet for the child. Further, the efforts of the parent here can be taken as an indication of the good parent device highlighted in chapter 6 whereby moral adequacy is invoked for the parenting. Clearly Mrs Roberts orients to an identity construction of a concerned, well read and active parent in her child's health. Ultimately in this narrative both the food additive and organic food options are dismissed as viable explanations (i.e. "so what's the point of organic yeah you might not have all the pesticides but the problem might still be there because its in the ground…" (lines 14-15). However, what is clear is how the narrative succeeds in negotiating the parental responsibility for food and is further evidence of the wide array of aspects relating to the Environmental repertoire which are available and speculated here and which has been implicated in ADHD. Finally, in extract 4 of the original analysis from chapter 6 the simultaneous use of both the Biological repertoire and the Environmental repertoire was most apparent and is considered further below.

Extract 4; Chapter 6:

Parent Interview 9: Mrs Henderson of James

I: Tell me about your child
P: […] is there such a thing as ADHD or is it something (.) to do with when the kids are born or (.) when my husband and I split up when James was about two and a half (.) something to do with attachment so I'm not very sure just now
I: what do you (.) what do you think
P: I'm not sure I'm kind of undecided at the moment (I: yes) is it a biological thing or is it (.) is it to do with er (.) your up your social environment […] I mean I hadn't heard about all these things (.) and I do wonder whether it has been something to do with attachment theory cos my husband worked away (.) a month and was home a month or before that he worked away (.) em ten days and home for a couple a' days cos he was at [name of company] and I was working full time so we always had somebody looking after the kids

This extract is significant for a number of reasons. Firstly, mirroring extract 6, chapter 6, Mrs Henderson was also seen to be speculating on the possible environmental origins of the child's difficulties (i.e. line 2 "is it something (.) to do with…" and lines 8-9: "and I do wonder whether it has been something to do with attachment theory …"). Further, the extract is unique because Mrs Henderson clearly articulates both the Biological Repertoire and the Environmental Repertoires simultaneously. While parental narratives did tend to orient towards both repertoires these did not always occur simultaneously and in such contrast as in this extract. What is significant here is that the Biological and Environmental repertoires are articulated as discrete and opposing explanations. In other words, from this narrative it is not possible that the difficulties could be both biological and environmental in nature. In addition, while Mrs Henderson puts forward the social environmental explanation for the child's difficulties, she proceeds to elaborate on aspects of the early parenting that may have been implicated in creating such difficulties rather than on other aspects of the child's environment (i.e. the school environment). Thus environmental aspects, like in extract 6, are reduced to aspects concerned with parenting issues.

In line with this argument, it was further noteworthy that the use of the Biological repertoire amounted essentially to a genetic explanation for the child's ADHD while the Environmental repertoire amounted essentially to parenting issues (i.e. as divorce, as separation anxiety, as maternal stress and anxiety). What is significant is that within these Environmental explanations it was parenting aspects that emerged as issues. It is clear that they draw from wider notions in current research relating to 'risk' and 'protective' factors to do with parenting for ADHD. Thus, what is striking from the analysis is that the 'psychosocial' aspects implied within a biopsychoscial model for ADHD were essentially reduced to issues to do with parenting. Through the rhetorical device of the 'good parent', parents invoked themselves into ADHD causal pathways. Wider schooling, social practices and cultural and economic arrangements are not given scope in such accounts where negotiations of parental accountability featured prominently. So it is argued that through the deployment of the competing repertoires, parental 'risk' factors for ADHD were largely invoked through the Environmental repertoire as a multiple means of implicating parental accountability. As discussed above, this is tied to contemporary Western individualistic emphasis in health and illness and which

similarly places parents as responsible for their child's health and well-being, at the expense of the broader social and cultural milieu.

It is argued that the theoretical criticism of the biopsychosocial model for ADHD (as outlined in chapter 2) is significant for the present analysis. The analysis demonstrated how the biopsychosocial approach to ADHD was taken up and produced in everyday accounts by parents. Theoretically, the criticism in chapter 2 highlighted that despite the biopsychosocial attempt at incorporating a 'holistic' approach to ADHD (e.g. Cooper, 2001; Singh, 2001; BPS, 2000) in order to accommodate a multiplicity of causal factors, a form of biological reductionism was maintained. Against these theoretical considerations, however, this analysis highlighted the limits of the biopsychosocial model in parental social practices. Clearly parental talk reduced accounts about causality to genetic/ biological factors as well as a range of past and present parenting issues. However, the analysis highlighted how it was that the Biological repertoire was able to achieve precedence in accounts. Thus it is clear that accounts worked to accomplish a form of biological reductionism in practice. Such parental accounts appeared unable to accommodate such 'holistic' causal explanations for their child's ADHD but were defined as fragmentary and dichotomous. Evidently the repertoires were emphasised as separate and discrete ways of talking about ADHD. This was evident in how the repertoires appeared in isolation from one another as well as the sheer tentativeness which characterised the Environmental repertoire. The past and present parenting explanations which were posited for the child's difficulties highlighted the pervasive and multiple means through which parenting could be implicated causally as 'risk' factors (i.e. through stress and anxiety in pregnancy, separation anxiety, parental divorce). There was great discursive elaboration required in order to present an identity consistent with a 'good parent'. Thus, parental talk offered reductionistic accounts for the child's difficulties which tended to reinforce individualistic notions which see the parents as essentially responsible for their child's health and behaviour. The 'psychosocial' explanations in these accounts, as highlighted above, amounted to parenting aspects which were superseded in talk by biological explanations and thus did little to challenge biomedical accounts for ADHD. Ultimately then, such biopsychosocial accounting in parental talk appeared limited and fragmented.

The 'good parent' device in ADHD talk

What was significant about parental accounts was that in relation to talk about diagnosis, great discursive work was required in order to produce the 'good parent'. In other words, the complexities of the discourse showed that when diagnosis is treated as a discursive event (rather than an actual scientific event), it was tied to extensive and elaborate accounts which worked to constitute the good, morally adequate parent. This was in evidence in the longer extracts 7 and 8 in chapter 6 which highlighted the detail and elaboration invoked whereby the 'good parent' was achieved discursively. This occurred in a single interview (extract 7, Mrs Morrison) as well as a joint interview with both parents (extract 8, Mr & Mrs Johnston). Previous qualitative literature suggested that maternal blame was a particularly salient feature amongst mothers of children with ADHD (as highlighted in the qualitative review in chapter 3). Fathers, by contrast, have received limited attention. Within the parent analysis it is useful to consider the 'good parent' device in relation to talk by both mothers and fathers. Thus the joint interview from chapter 6 is significant in this respect and part of this extract is reproduced below.

Extract 8; Chapter 6

Parent Interview 6: Mr & Mrs Johnston of Jessica

M: and and you do you think what have we done wrong this time
I: so you blame yourself
F: you see we we're quite old-fashioned even though we're just in our forties we're quite old-fashioned in the way we were brought up (I: mhm) we still think them values count today as well (.) […] and =
M: =we believe in kind of morals
F: =manners and morals and
M: yeah
F: and you know being (.) quite well brought up
M: yes
F: and we try to keep to our (.) I know a lot of parents today don't do that (.) but we do (.) and um (.) it's like if they get into trouble (.) I've I've warned then if you get do something that's wrong I'll be the first person to march you up to the police station (.) they know that (I: yes) because we don't put up with that sort of thing ()
M: = a lot of parents wouldn't do that they'd be saying to the police 'oh' (I: laughs)
F: yeah
M: so I mean but that's how we were brought up and that's=
F: = that's the sort of how we trying to be with them (.) some people think we're too strict […]

From the above, it was Mrs Johnston that oriented to blame and parenting issues (i.e. in line 1: “you think what have we done wrong this time”). When the interviewer probed in line 2 with: “so you blame yourself”, it was noteworthy that Mr Johnston took up the next turn with: “you see we’re quite old-fashioned even though we’re just in our forties we’re quite old-fashioned in the way we were brought up (I: mhm) we still think them values count today as well (.)” in lines 3-5. This signalled part of the later co-construction between the Johnston’s towards the moral character of the parents (i.e. seen in the repetition of “moral and manners” in lines 6 and 7). What is further significant here, is how during the course of the narrative about parental blame, that Mr Johnston’s elaboration in lines 3-5 and lines 11-14 established the bounds of the parental ‘good’ character. Hence it is significant that parental talk orienting towards the good parenting occurred by both the Johnston’s as well as Mrs Morrison and does not appear a feature restricted to maternal narratives only. It is useful to consider a single interview by a father in relation to the workings of the good parent device. The following extract is considered for further analysis.

Extract 2

Parent Interview 4: Mr McKay of Liam

P: […] cos I work I work () em (.) it’s a bit of a frustrating thing and embarrassing as I say when you go to the shops and (.) I don’t like cheeky children basically (I: yeah) er I come from quite a strong em (.) family life myself and (.) I find it hard to cope to a certain extent with a child so cheeky and so disruptive and (.) it’s not that it’s correct but I have smacked him in the past (I: mhm) and I felt I shouldn’t do so (I: yes) never liked doing it not liked it at all I have done it (.) mainly when he’s been really really cheeky to his mother and got her upset (I: yes) and I’ve given him well a couple of slaps to his bum and put to his bed so to speak (I: mm) but that’s rare rarely do that I don’t like doing it but sometimes you feel so frustrated that you don’t know what else to do […]

In the above extract, it is clear that Mr McKay engages in a risky discursive move whereby he discloses the “smack[ing]” (line 5) incident. Smacking a child is not currently condoned in current notions of child care as an effective means of discipline. In this context, however, Mr McKay invokes the notion of the ‘good’ father as someone from a “stong em (.) family life” (line 3) and who is concerned with disciplining their child and who is not tolerant of “cheeky” and “disruptive” behaviour (line 4). This orientation serves as a kind of justification so that the child’s behaviour is not seen as being due to faulty or lax parenting. Instead this notion is reversed whereby Mr McKay invokes the character of a parent very concerned with discipline

and tends to parallel notions of a good father. A further function is to highlight the sheer desperation of the father in the sense of a last desperate effort at establishing parental efforts at discipline when confronted with a child with extreme behaviour. Mr McKay's extract resembles the earlier discursive turns by Mr Johnston in which – rather than being seen as somehow lacking in parental discipline efforts – both fathers orient towards an identity of being seen as "strict" (Mr Johnston) and "strong" (Mr McKay). It is noteworthy that the moral character of the 'good father' is oriented towards strict and authoritarian values and can be heard against commonly held lay beliefs which circulate about ADHD whereby the parenting of such children are held to be somehow lacking in discipline. Thus the good parent device can be seen to be a characteristic of both maternal and paternal narratives which is significant.

Finally, it is useful to consider the broader literature on parenting style and ADHD. In the study by Lange et al (2005), for example, an authoritarian parenting style was in fact associated with parents of children with ADHD. Thus such 'good parenting' efforts by Mr McKay and Mr Johnston which relied on an identity construction of strong moral values and a concern with disciplining behaviour may in essence be undermined ultimately by theoretical work in ADHD which has implicated these exact authoritarian parenting styles as a characteristic feature of ADHD parenting. Thus it is argued that despite discursive efforts that attended to the Environmental repertoire in parental narratives, biopsychosocial models in ADHD which implicate a wide array of biological, parenting and social influences into ADHD causality may ultimately entail that further aspects of parenting practices are centralised and scrutinised for their role in ADHD. As seen in the previous section, environmental explanations for ADHD may often be reduced to aspects concerned with parenting practices. It is argued that this may serve to ultimately disempower parents further. What is significant is how susceptible such parenting practices are to critique when, for example, *both* a lack of effective discipline as well as authoritarian parenting has been variously implicated in the parenting styles of ADHD children from empirical work as well as lay theories. There is evidence of this paradox in the data if we consider the following extract from the joint interview with Mr and Mrs McCormack (as highlighted below).

Extract 3

Parent Interview 8: Mr & Mrs McCormack, guardians of Gary

I: so you you said um earlier that you started to think it was you
M: yes (.) we because um (.) well what he was fourteen months when we got him so that would probably be about a year later or that that we just thought it was (.) we werenae (.) doing it properly and maybe givin' him too much leeway **we weren't strict enough or that or too strict** (.) cos we used to get the usual even still what ten years later 'oh aye if it was my son I would no he wouldnae be like that' or 'give me him a week and he'll e different from that' and that really annoys us

The widespread use of the 'good parent' device in parental narratives means that prior work from a humanist approach (as reviewed in chapter 3) is clearly limited in terms of the study of a diagnosis of ADHD for parents. The analysis suggests that, rather than exonerating parental blame (i.e. Klasen, 2000; Kendall, 1998), that parental accountability for their children's difficulties is a discursively produced and complicated temporal accomplishment in research interviews. Further, that in view of the incomplete medicalisation of ADHD in the UK, these discursive accomplishments may be required and produced in other settings in order to establish ADHD as an explanation. Parental accountability, then, is considered likewise as a discursive accomplishment in talk which is transient and in the context of a controversial condition negotiated in talk, despite an 'objective' diagnosis.

In addition, a further significant feature in talk about diagnosis was that while the Biological and Environmental repertoires were produced in the context of accounting for the *origins* of the child's difficulties, it was significant that diagnosis talk oriented to *present* parenting practices and issues. This served to emphasise the continual and extensive work that parents were required to engage in to achieve the Biological repertoire. It highlights the scrutiny and endless possibilities within the parenting which could be held accountable for the child's difficulties from past to present forms of parenting practices. That these were held accountable in research interviews indicates that parents themselves were engaged in a type of self-scrutiny of their own practices. The Foucauldian 'gaze' and 'surveillance medicine' (i.e. Armstrong, 1995) is reminiscent here where lay parents oriented to their own possible actions in producing 'deviant' children. The dominance of the Biological repertoire indicated that lay parents, too, engaged in a form of medicalisation of the child's difficulties in order to be deemed morally adequate as parents and indicates lay collusion in this process. However, it is argued that given current views of health and illness which deem individual responsibility for health and illness as key, and

given the centrality of the parents (especially mothers) in child development theories about the successful 'outcome' of the child, parents remain positioned as inescapably responsible for a child's difficulties. This is a central feature of current Western dualism which emphasises individuo-centred accountability and requires that morally adequate individuals be accountable for their actions. Thus it is argued that the construction of a 'good parent' is always transient and open to challenge from various guises and always in the face of such individuo-centred conceptions which implicate accountability.

Thus, in keeping with others who have written about the limits of individuo-centred conceptions within health and illness more generally and in ADHD particularly, this work maintains that greater medicalisation of the ADHD construct in contexts such as the UK is limited and should be critically re-examined. Medicalisation of children's difficulties as ADHD does not appear to be an exonerating concept. At face value the benefits of medicalisation are recognised, however, in line with others (i.e. Singh, 2003; Bull and Whelan, 2006), such medicalisation as a discursive practice is limited in view of the competing Environmental repertoire which implicated an array of parenting influences into causal associations. Such emphasis on parental accountability and responsibility is rooted in individuo-centred assumptions within health and illness and does little to consider broader socio-cultural and historical influences in such constructions as ADHD.

Finally, it is worth considering the 'good parent' device and the use of semi-structured interviews of data collection. The critique may be levelled at the use of semi-structured interviews to elicit talk about ADHD whereby parental blame may be regarded as a feature of the research interview itself. Research interviews are not neutral or naturalistic means of data collection and the argument may be that parents oriented towards a professional interviewer with a background in psychology and clearly an 'outsider' from the area. However, while it is conceded that parental talk would have attended to features of the research interview such as question and answer turn-taking, for example, it is held that parental blame arose spontaneously from the data in relation to talk about the topic. It is argued further that in the context of ADHD, it is likely that the research interview may have been simply one of a number of areas (i.e. such as shopping malls, schools, extended families) which were invoked in talk, whereby parents felt scrutinised and held accountable for the child's behaviour. In general parents reflected positively on their experiences of

taking part in a research interview in terms of an opportunity to discuss their experiences about this topic.

The 'Expert' Parent versus the 'Ignorant' Teacher in ADHD

Other findings from the analysis demonstrated how parents were essentially able to hold medical views about their child in the face of competing views by others such as schools or families. There was a larger parallel drawn with this work on lay parents and Gilbert and Mulkay's (1984) classic study of biochemists' discourse and use of the Empiricist accounting device. In the present study, the parallel was drawn because it highlighted how parents, in the context of their own views, oriented to medical views (as explanations rooted in the Biological repertoire) and oriented to competing views in terms of personal failings (explanations rooted in the Environmental repertoire). Thus medical views relied on alignments with experts such as paediatricians and child education experts. In addition, medical views were characterised by specialist and expert knowledge about ADHD. In contrast, competing views were held as due to personal failings, ignorance and bias. In order to overcome these competing views, parental accounts resorted to: getting ADHD 'out there' and the analogy with cancer as disease. This device worked in a similar fashion to Gilbert and Mulkay's (1984) 'Truth will out' device. Lay parents are clearly not scientists, but it is argued that their accounts clearly accomplished similar functions with the 'out there' rhetorical device and the analogy with cancer. The data referring to cancer is reproduced here from chapter 6.

Extract 12; Chapter 6

Parent Interview 2: Mrs Roberts of Ian

P: it's like it's an alien (I: oh) I mean see years ago cancer was never a word (I: yes) and **nowadays cancer's everywhere and everyone's accepting it but it's taken years**

Extract 13; Chapter 6

Parent Interview 4: Mr McKay of Liam

P: **I mean they've got charities for cancer etc. left right and centre** (.) and yet ADHD (.) I can't even remember it being on the television

The contrast between cancer and ADHD is worked up in these extracts and is clearly significant, it is argued, because cancer has a widespread acceptance as a serious and widely recognised disease within contemporary society. It is contended that through the likening of ADHD to the cancer disease metaphor that a biological basis for ADHD is further achieved. This serves to undermine alternative environmental explanations and so functions to position the parents as unfortunate victims of limited advances in medical science, including a lack of public knowledge about ADHD and a lack of public resources for ADHD. Hence, the analogy with cancer is significant because ADHD is constituted in physical disease terms. However, the ADHD as disease metaphor is not only worked up in relation to cancer. Other disease comparisons with ADHD were hearable as can seen from the following extracts.

Extract 13; Chapter 6

Parent Interview 4: Mr McKay of Liam

P: if folk understood that hyperactive children aren't just bad children (I: mhm) **they have got a slight illness**

Extract 4

Parent Interview 5: Mrs McKay of Liam

I: How do you feel about the controversy surrounding ADHD (.) sometimes people you know some people think that it doesn't really exist
P: I think a lot a' older people are like that em (.) and for younger people it's the same because they don't know anybody that's got someone then they're oblivious to it (.) but I think that's probably the general opinion with any (.) **like if you've not got a kid with autism then you're not gonnae know what somebody's like** (I: mhm) em it's only until you read into something *yourself* (I: yes) or if you've had somebody that's in your family that's got something **like that or any sort a' disease or illness** (I: yeah uh huh) and **like people that's got Parkinson or ME or (.) (I: yes) until you know somebody that's got that then** (.) (I: you're not gonna know) you're not gonna know a lot about it (I: yeah) em that's the way I feel eh (I: yes) because I feel

12 I've had to go out and fend for myself on things on ADHD (I: yes) em (.) so I've read
13 books and my parents they've read up too

From the above extracts, Mr McKay moves from the analogy with cancer to describe ADHD as a "slight illness". ADHD as an "illness" appears elsewhere in his narrative. The significance here of "slight" is noticeable as orienting to the possible incompatibility with ADHD as an illness like cancer because of the controversy surrounding ADHD. Extract 4 is significant because of the range of comparisons apparent (as highlighted above). In direct response to the interviewer's probe about the controversial status of ADHD (i.e. "How do you feel about the controversy surrounding ADHD (.) sometimes people you know some people think that it doesn't really exist"), Mrs McKay's response is significant. From what follows it is clear that Mrs McKay makes use of the significance of expert knowledge about ADHD as seen in: "because they don't know anybody that's got someone then they're oblivious to it (.)" (line 4). This is worked up as a generalised feature in line 5 with: "but I think that's probably the general opinion with any…". In addition, the comparisons that follow deserve consideration: "like if you've not got a kid with autism then you're not gonnae know what somebody's like (I: mhm) em it's only until you read into something like that or any sort a' disease or illness (I: yeah uh huh) and like people that's got Parkinson or ME (.) " (lines 5-9). Firstly, ADHD is likened with autism in the extract, it is then generalised and extended to "any sort a' disease or illness" and finally linked with "Parkinson or ME". It is significant that in such lay narratives, ADHD is worked up as simply one of a number of serious and debilitating diseases whereby public ignorance is considered natural. The diseases and illnesses specified here are clearly very different. While autism is often paralleled with ADHD over its developmental course in childhood, Parkinson's and "any sort a' disease or illness" are seen as physical and biological in nature. Finally, ME is another controversial condition with unclear aetiology and it is interesting from this extract that these aspects are not discriminated.

From chapter 6, greater knowledge and publicity about ADHD in the face of widespread ignorance and bias, would contribute to getting the 'truth' 'out there'. This analysis and use of the rhetorical device of 'getting ADHD out there' was employed in research interviews, and may be key in other contexts. For example, one of the fathers at the end of the interview considered that it was my role as the interviewer and researcher to disseminate 'knowledge' about ADHD to such organisations as Disability Living Allowance so that they could be more informed

about ADHD (i.e. “yeah if you could put it across because people need to be educated” about ADHD). A further example is seen in the slogan at a national ADHD conference in 2006 as: *Enough’s enough!!*. At the heart of such endeavours is the attempt to disseminate knowledge about what ADHD is and dispel ‘myths’. Such attempts clearly have political connotations (i.e. such as the attempt to lobby the government through petitions). Thus, it is argued that the rhetorical device of ‘getting ADHD out there’ is relevant and shows how such discursive devices may be tied to, and have material implications, for political means both within and outside the context of the research interview.

The significance of the above is that it demonstrates how parental talk was able to use expert ADHD ‘knowledge’ in order to undermine other experts, particularly teachers. Such rhetorical use of expert ADHD knowledge functioned to give parents a means of undermining alternative and competing views by such teachers. It is further argued that in doing so, parental accounts of teachers’ views worked to disempower teachers through the parallel with the Empiricist accounting device whereby such teachers were constructed as ignorant and biased in the face of expert and specialist knowledge about ADHD. This emergence of the ‘lay’ expert in ADHD is in keeping with wider work in sociology (e.g. Prior, 2003) and further parallels Rafalovich’s (2004) findings about parents in a North American context, where parents used knowledge and information to empower themselves in that context. Other literature which highlighted maternal efforts in vigilante terms against the medical and educational services, again in a North American context (i.e. Blum, 2007), further suggests such political connotations.

Parental positioning and talk about Ritalin

Finally, the analysis also considered the available subject positions for parents in relation to talk about controversial medications like Ritalin and in relation to parental status as a ‘good parent’. Talk about medication in ADHD is important because it allows understandings about treatment ‘adherence’ by parents in view of the significant role that parents play in the treatment choice for ADHD. The analysis highlighted two significant subject positions in talk which were temporally invoked by parents. One such subject position involved the passive recipient in the face of external circumstances and a lack of other treatment options. For example: Extract 14 in chapter 6, Ms Buchanan of Sean: “well (.) it was either you put up wie it or (.)

the only other option was to hav' medication (I: mhm) so there's no really (.) no other way out eh (I: yes) really". An alternative positioning available was that of active parental resistance to coercive efforts by medical professionals. Central to this position was the notion of having other 'options' to the medication and of inner, personal qualities consistent with a 'good parent'. For example: Extract 17 in chapter 6, Mrs Morrison of Adam: "if you can talk the talk (I: mhm) you come across as switched on intelligent da-da-da…". This construction, it is argued, is in keeping with the emergence of the 'Expert' parent (as discussed above). In addition, in extract 17, it is Mrs Morrison who initiates and informs the "unimaginative" paediatrician about the possible nutritional aspects involved as opposed to the focus on medication.

It is useful to consider a negative cases analysis in regards to constructions of identity in relation to the medication. Negative case analysis or exceptions in discourse analysis are considered significant because the exploration of exceptions may be revealing in terms of the overall analysis (Potter and Wetherell, 1987). The original analysis in chapter 6 was concerned with the exploration of parental subject positions which were in distinct contrast with health policy guidelines for medication. Further analysis of talk about medication is considered below which may be considered a negative case because it appears to differ from the two patterns explored in chapter 6.

Extract 5

Parent Interview 6: Mr & Mrs Johnston of Jessica

I: […] and how did you feel about um Ritalin
F: we heard bad things to start off with
M: yes all the write-ups
F: () stick em on Ritalin you know it's a bad thing (.) actually it's done really well
M: yes all the write-ups you you (.) I think they do tend to (.) paint a bit of a dark picture (I: um) um but then that's tabloid newspapers for you (I: yeah) and a lot of the the write-ups that you do get even in some of the more reasonable papers (.) they don't always give both sides of the story (I: mhm) which is a shame
F: a person reacts differently to different tablets (I: yes) and Jessica's done quite well with it you know (.) there are some other children that may react badly with it so (.) you know same as normal pills (I: yes) may not work in other (situations)
M: yeah I mean (I: uh huh) I mean at the end of the day **certainly as a nurse** (.) my point of view is if it's gonna benefit Jessica then (.) I don't have a problem with it (I: yes) if it's not really gonna give her many benefits and a lot of side effects from it then ok we'll possibly (.) weigh that up (I:um) whether it's actually worth (I: yes) the the kind of the problems that that may cause in itself but if it doesn't cause any side-effects and you get all the benefits from the medication then hey why not because in theory it's making her life better (I: yes) and in turn that will make our life better um and more straightforward I mean if we'd had problems with the medication I'd have

gone back to Dr X and said you know (.) look (F: um) I'm not too keen on this (I: yes) is there something else we can try (.) but unless you try all the various avenues (.) um (.) you know (.) you you can't make a a really (.) proper informed decision (I: yeah) I think a lot of people have a bit of a blinkered view and they say 'oh we don't want to do that because of this' (I: yes) um (.) but if you don't try that to know if it works or not how can you say (.) I don't want to do it

This extract is interesting from a discourse analytic perspective because at first glance it appears as an exception to the previous extracts produced about parental talk over medication in chapter 6. Like the previous extracts the Johnston's also orient to the stigma and negative aspects surrounding the medication as seen in Mr Johnston's initial response to the interviewer's question: "we heard bad things to start off with" (line 2) and Mrs Johnston's: " yes (all the write-ups)" (line 3). However, unlike the previous extracts, the Johnston's co-constructive account that follows orients towards an alternative account. This is seen with Mr Johnston's move from: "() stick em on Ritalin you know it's a bad thing (.) actually it's done really well" (lines 4-5) and Mrs Johnston's: "yes all the write-ups you you (.) I think they do tend to (.) paint a bit of a dark picture (I: um) but then that's tabloid newspapers for you" (lines 6-8). This is significant because an alternative construction of Ritalin or medication is heard which does not appear in purely negative terms. Instead "it's done really well" (line 5; note that it is unclear in what way Ritalin has done well and this was not probed by the interviewer). Similarly Mrs Johnston's turn to speak of "tabloid newspapers" is also significant, it is argued, because this constitutes a turn to talk about the parental identity. It is noteworthy that the Johnston's can be heard as unlikely readers of tabloid newspapers and clearly as unlikely to base decisions about their child's health on the readership of such unreliable sources. The parental identity is further heard as someone likely to be a reader of "more reasonable papers" (line 9) and thus intelligent and discerning. Mrs Johnston appears critical of such papers with: "and a lot of the the write-ups that you do get even in some of the more reasonable papers (.) they don't always give both sides of the story (I: mhm) which is a shame" (lines 9-11). Such orientation to the moral character of the parenting resembles the previous extracts about medication, particularly extracts of resistance. In addition, the Johnston's have worked in this extract to produce a contrast of the negative aspects surrounding Ritalin with an alternative construction which sees Ritalin as being unfairly reported and biased in the media. Mr Johnston's turn following that is to highlight individual differences with medication use and to the success of the medication with his own daughter: "a person reacts differently to different tablets (I: yes) and Jessica's done quite well with it you know (.) there are

some other children that may react badly with it so (.) you know same as normal pills (I: yes) it may not work in other (situations)" (lines 12-15). This alternative construction to the medication is in contrast to previous extracts about medication use amongst parents. It is effective because Mr Johnston likens Ritalin to the working of uncontroversial "normal pills". A significant aspect of the departure of this extract occurs in the following lines with Mrs Johnston's turn: "Yeah I mean (I: uh huh) I mean at the end of the day certainly as a nurse (.) my point of view is if it's gonna benefit Jessica then (.) I don't have a problem with it (I: yes)" (lines 16-18; highlighted above). Mrs Johnston's orientation to speak "certainly as a nurse" is significant in this context because her subject position shifts from a parent to a nurse. Hence, from this position Mrs Johnston is able to comment with authority on the suitability of Ritalin as a form of treatment from her professional status rather than as a lay parent. This is a distinguishing feature of this extract which occurs in contrast to the other extracts. Clearly it may be sensitive for parents to discuss and justify the use of a controversial medication for their child. This extract highlights how the parental narrative relied on talk about the good character of the parenting – which was also seen in parental talk about resisting medication. What was different, however, was the additional orientation to the subject position as a nurse in order to be heard as credible. This has further resonance with the earlier section of the expert parent whereby Mrs Johnston is clearly both a parent and a nurse and thus knowledgeable about this topic.

Finally, there are limits with the drawing of conclusions in relation to wider medical practices, due to the discursive stance taken in this work which emphasises talk as occasioned, temporal and situated. However, the subject positions oriented to and highlighted in the analysis are taken as significant in relation to the rhetoric of local treatment guidelines (SIGN, 2001). The subject position employed of the passive recipient with a lack of alternative treatment options appears in contrast to the rhetoric of medication as a 'treatment package'. In addition, the subject position of the parent as engaged in active resistance to medical coercion also appears against these guidelines. Such 'resistance' efforts appear in keeping with the wider literature in relation to parental dislike of ADHD medications as indicated previously (e.g. MTA study, 1999; Bussing et al, 2001; 2002). Further, the parental accounts of 'resistance', highlighted that accounting for medication refusal and following alternative options was a difficult discursive manoeuvre to articulate. This emerges as an area requiring further analysis. As reiterated above, while there are limits of

making conclusions based on the discursive position adopted which does not take accounts at face value. What was clear, however, was that parental empowerment in talk about medication treatment was limited. Finally, the negative case analysis indicated that professional status as a nurse was oriented to in order to justify such treatment choice but that ultimately a similar means of identity construction was an issue and was achieved in relation to 'good' parenting talk.

Findings from the Teacher Analysis

There were a number of key insights from the teacher analysis. Such analysis highlighted how teacher talk differed to that of the parents. Teachers made use of an ADHD repertoire and a Not ADHD repertoire in order to account for children's difficulties and when introduced as topic by the interviewer. Such talk centred on the role and management of the teacher in the classroom. The analysis highlighted how teacher talk made use of the 'cases I know' device in order to accomplish the difficulties as due to temporal behavioural difficulties rather than a medical condition. Teacher talk presented alternative explanations for diagnosed ADHD as due to instances of misdiagnosis and mistreatment. Through talk about such misdiagnosis and mistreatment, talk oriented to a range of controversies in the literature surrounding ADHD including its validity as a construct and the long–term use of medication. In doing so, teacher accounts highlighted considerable knowledge of the area and thus serves to challenge ADHD proponents who regard teachers as merely ignorant in the UK. These findings are discussed further below.

Teacher Talk about ADHD and Poor Parenting

The analysis in chapter 7 highlighted two opposing and contradictory repertoires in teacher narratives centred on the ADHD repertoire and Not ADHD repertoire. It was suggested that the use of these repertoires may have arisen from the use of the research interview. This is considered further. The following two extracts are reproduced from chapter 7.

Extract 1; Chapter 7

Teacher Interview 3: Head Teacher of Sunnyville Primary

I: What does ADHD mean from your perspective
T: well er this this is it I mean (.) it seems to be a very sort of flexible kind of (.) definition

Extract 4; Chapter 7

Teacher Interview 5: Class Teacher of Greenwood Primary

I: What does it [ADHD] mean to you
T: (.) um (.) it's fairly new to me (I: mhm) um (.) I've been back into teaching [some years]…

These examples obtained from the teacher analysis highlight that it was the interviewer that introduced the topic of ADHD into the narrative (i.e. "What does ADHD mean from your perspective"). This is significant within the context of the research interview. While it may be expected that research interviews may follow a question and answer format, as noted in the previous section, the use of the term 'ADHD' can not be regarded as neutral within the wider context of controversy and it is acknowledged that the talk produced may have been different if a different phrasing of the question had been posed (e.g. "Tell me about how children with difficulties behave"). However, while it is clear that the interviewer in this analysis was responsible for initiating the term 'ADHD' into the conversation; it may be argued that this was also beneficial. Firstly, the term 'ADHD' appears in educational contexts as seen in current educational guidelines produced about ADHD which offer specific strategies and advice to schools for this topic (e.g. Cooper and O' Regan, 2001; Taylor et al, 2004). In addition, by posing this as a question itself (i.e. "what does it mean…"), the interviewer may have allowed probing of this term whereby teachers could elaborate on this topic (i.e. as seen in: "…this is it I mean (.) it seems to be a very sort of flexible kind of (.) definition" and "it's fairly new to me"). It is useful to consider what opportunities teachers may have in expressing such constructions outside the research interview. While such discussions may occur in educational contexts, it may be difficult for such questioning in the face of parental and medical professional use of ADHD diagnoses. This is taken up further below.

This analysis also points to the benefit of a discourse analytic approach for teacher's accounts of ADHD, as opposed to an approach which takes individual

accounts at face value. A discourse analytic approach, such as the version adopted here, is able to consider contradictory positions in interviews rather than expecting unified views for example. In these interviews teacher accounts were characterised by difficulty in the Not ADHD repertoire and this appeared as a somewhat sensitive topic to articulate. For example the class teacher in extract 8 of chapter 7 concluded that extract with: "I feel bad now" and: "I hate saying some of these things". Tied to this, in extract 5 the deputy head's: "that's not to say that I don't think there are children who *will* (.) have ADHD…" and extract 7's: "I'm not saying he *hasn't* got ADHD…" is significant as examples in which the teachers qualify and exhibit their own accounts as problematic. It was clearly difficult for teachers to offer alternative accounts for children's behaviour (at least in a research interview where the interviewer had refrained from offering their own view). Taking teacher statements at face value would tend to imply that teachers did accept and do 'believe' in ADHD. The value of a discourse analysis, however, highlights the complexity of such talk and the organisation which functions to resist such medical accounts. Furthermore, the difficulties characterising these extracts in articulating these alternative accounts for children's behaviour, means that it is possible that as the ADHD phenomenon becomes more widespread, critical debate and alternative explanations for such behaviour may be increasingly forestalled. Such a climate was illustrated by an anecdote by one of the teachers who referred to a recent media story which reported that teachers were not doctors and thus should refrain from casting their opinions on this topic. Thus, presenting an alternative construction of the child's difficulties in competition to that of ADHD was clearly a difficult discursive manoeuvre and may be increasingly difficult to produce in other contexts. Such contexts as school review meetings and interdisciplinary meetings etc. may be particularly important.

'Poor Parenting' as explanations for Children's Difficulties

The review in chapter 3 highlighted that there was a lack of research in the ADHD field focused on teacher accounts in relation to parental blame and whether teacher accounts *did* actually tend to orient towards parental accountability for their children's behaviour. While there was anecdotal evidence from the parent interviews that teachers did not 'believe' in ADHD, empirical analysis of teacher's accounts of children's difficulties in chapter 7 highlighted the discursive use of the Not ADHD

repertoire. The Not ADHD repertoire was heard as an elaborate and alternative construction for children's difficulties which sought to undermine explanations that the child had a constitutional condition as ADHD. In the Not ADHD repertoire the various origins that were posited to account for the child's difficulties were hearable from chapter 7 and are reproduced here.

Extract 5; Chapter 7

Teacher Interview 7: Deputy Head Teacher of Newville Primary

T: […] there seems to be (.) **some (.) problems in parenting** (.) […] my sort of feeling about it is that it's probably a a (.) **sort of environmental problem** (I: ok yes) rather than biological […] from my point of view (I: mhm) *no* I don't think the child [has] ADHD it's just (.) **poor parenting** […] and it's **basically just no parental control**

Extract 6; Chapter 7

Teacher Interview 3: Head Teacher of Sunnyvale Primary

T: *I I* see it as more behavioural than medical (I: mhm) um but I *do* feel that er (.) a lot of the children who are diagnosed with ADHD (.) have (.) been er (.) **brought up in a certain way (.) and er (.) certain behaviour patterns are established** at an early stage which are then very difficult to break […] you know that they're not given clear boundaries and so on when they're children um (.) they're allowed to do pretty much whatever they want and so on […]

Extract 7; Chapter 7

Teacher Interview 5: Class Teacher of Greenwood Primary

T: […] with *him* I think a lot of it is (.) ***learned behaviour*** I had my doubts at first as to whether or not he was ADHD […] and I just feel at this stage that you know getting him young in school (I: mhm) you know we're just trying to (.) undo that behaviour sort of thing

Extract 8; Chapter 7

Teacher Interview 8: Class Teacher of Newville Primary

T: […] perhaps some of the cases are perhaps not ADHD (I: mhm) but perhaps **lack of (.) em rules boundaries parental guidance** (.) perhaps going through a family (.) you know if a parent hasn't had the support when they were younger (I: yes) then I think there are **many social issues** that also go (.) around ADHD […]

The orientation to poor parenting as accountable for the child's difficulties is clearly evident from the above (i.e. "poor parenting", extract 5; "lack of (.) em rules boundaries parental guidance", extract 8). The implication is thus that the child has learned such behaviours rather than inherited a biological condition (i.e. "certain behaviour patterns are established", extract 6 and "learned behaviour", extract 7). It was previously argued in chapter 7 that it was significant that while teachers did orient to both an ADHD repertoire and a Not ADHD repertoire in their talk but that they tended to orient to the ADHD repertoire as an abstract entity only and that their accounts were characterised by instances describing NOT ADHD. In the details which characterised the Not ADHD repertoire in these extracts, as seen above, it was clear from within teacher accounts that poor parenting was hearable as an explanation for children's difficult behaviour. Thus teacher accounts *did* appear to orient towards parental accountability in order to explain children's difficult behaviour in contrast to a medical condition of ADHD. This is an important empirical finding because little research has actually examined teacher accounts in a UK context. Thus, the analysis of teacher accounts here highlighted that teachers did hold parental accountability central in accounts for children's difficult behaviour. In addition, it is clear that while there was an allusion to environmental aspects that were involved in the child's difficulties in opposition to a medical construction, the specificity of these environmental influences remained rooted with the parenting. For example, extract 5 orients to: "a (.) sort of environmental problem" but emphasises "poor parenting". In extract 6, being: "brought up in a certain way (.) and er (.) certain behaviour patterns are established at an early stage…" is clearly heard as direct invocation to the parenting. Extract 7's emphasis on: "*learned behaviour*" orients to learned behaviour within the home context rather than the school context in accounting for the difficulties by reference to similar behaviours by the brothers. In extract 8, while reference is made to: "many social issues that also go (.) around ADHD…", it is only familial aspects that are discussed (i.e. "lack of (.) em rules boundaries parental guidance…"). From these constructions it is clear that teacher's talk drew from environmental influences for children's difficulties and paralleled wider educational discourses which emphasise early environmental influences. It is significant that in drawing from environmental influences in this way, the emphasis was placed on parenting influences as opposed to educational environmental influences which means that teachers succeeded in eliminating their own accountability for such behaviours. The emphasis on the parenting can be heard as

a reductionistic argument. What is noticeable about these explanations, therefore, are clearly that such accountability and responsibility rests with parenting rather than with the need for specialised teaching strategies or techniques in the classroom. If the child's difficulties are due to poor parenting, rather than a medical condition, then the implication is that teachers will be required to manage such difficulties as they traditionally have been required to manage children's behavioural difficulties rather than take responsibility for adaptation to a medical condition.

The Role of the Teacher and 'getting the balance right'

It is necessary to explore teacher's subject positions empirically in relation to the data and the above. From the previous extracts it was clear that there was some evidence of teacher's orientations to their own role and objective in the management of the child as seen above in: "certain behaviour patterns are established at an early stage which are then very difficult to break" (extract 6) and: "and I just feel at this stage that you know getting him young in school (I: mhm) you know we're just trying to (.) undo that behaviour sort of thing" (extract 7). From this it is clear that the teacher's prerogative is to "undo" behaviour that has been ultimately established as a result of poor parenting. This is heard as difficult from extract 6 (i.e. "which are then very difficult to break") but also as possible from extract 7 (i.e. I just feel at this stage that you know getting him young at school…") which is heard as an attempt to eradicate such corruptive or faulty patterns learnt from the parents. Thus the teacher's task is to deal with and manage such faulty behaviour. In the teacher analysis in chapter 7, teacher empowerment and control for the management of such children was explored according to the idiom of "getting the balance right" whereby teachers were required to negotiate their own empowerment to action. The following extracts in relation to the idiom are reproduced for further exploration of teacher subject positions concerning management of children with ADHD.

Extract 4; Chapter 7

Teacher Interview 5: Class Teacher of Greenwood Primary

T: […] so **it's the *balance* trying to get the balance right** (I: yes) um that's one of the most difficult things (I: yes) you know just how much is due to his condition (I: mhm) and how much is him just you know pushing us as far as we'll go (I: yeah) you know cos he's a bright enough little boy (I: oh yeah) you know so I think he could

also use his condition you know to push us (.) see how much he can get away with so it's really just you know trying to find that balance

Extract 2; Chapter 7:

Teacher Interview 6: Deputy Head teacher & Subject specific teacher of Harriston Primary

DHT: […] em quite a lot a' negotiation with that child (I: mhm) em sometimes too much negotiation cos I think we bed over backwards (.) sometimes to to you know accommodate=
SST: =and the further we bend the further they'll push us
DHT: =children **and sometimes it's difficult to get the balance right** between what is that child manipulating and (I: um) and what is (.) are real genuine difficulties (I: yes um) so it's about again *knowing* the child (I: um)
SST: there's a difference between someone that *can't* and someone that *won't*

Extract 6

Teacher Interview 7: Deputy Head of Newville Primary

T: […] maybe making too many allowances (I: oh) and so you're getting (.) you kind of **get in a muddle** with (.) is it actually the syndrome (I: mhm) that's that's fully (.) the child's behaving in that way because of the syndrome or is is also (.) the syndrome plus the way we respond to it (I: yes) and you know and I think that way we can get a bit muddled up

The above extracts were oriented towards the dilemma inherent for teachers in relation to teaching children diagnosed with ADHD. In the previous extracts from chapter 7, the idiom of "getting the balance" right was intrinsic to this dilemma. The additional extract orients to the same dilemma in terms of "get[ting] into a muddle" and "we can get a bit muddled up". This orientation refers to the delicate balance required between being manipulated by the child and genuine difficulties. The implications of this discursive positioning for teachers are explored further in relation to the following extracts which examine subject positions in relation to the dilemma; these are derived from a position of experience and inexperience.

Extract 7

Teacher Interview 3: Head Teacher of Sunnyvale Primary

T: […] but er it's difficult to sort of pin down because some (.) some of the children you sometimes feel well (.) they just can't help themselves that's just the way they are that's just what they're like (.) and and others you do feel that it's a more (.) calculated sort of situation um (.) and they can be (.) a bit more manipulative especially if they feel they have this label I mean I've had (.) I've had children say to me before and I've heard em (.) and I've heard (.) I know other teachers in other schools have similar experiences er (.) 'I can't help it I've got ADHD' you know […] I think on occasions parents will also er (.) use it as a justification for their child's behaviour (.) which (.) you know (.) fair enough but (.) but I I I wouldn't subscribe to the view that because a child had ADHD they are therefore unable to er (.) (laughs) control their behaviour and that they can (.) you know that they are therefore not accountable for their behaviour you know (I: um) so so sometimes that can cause a little bit of a er (.) misunderstanding with= (I: =oh yes) =parents

Extract 8

Teacher Interview 1: Subject specific teacher of Adenglen High

I: […] would you tell me about some of your experiences with pupils with ADHD

T: ok […begins talking of experiences with a pupil called Simon] it could get quite bad when he wasn't there obviously the class would be easier to handle (laughs) but all the kids were used to him behaving that way em (.) I used to make allowances because he had AD ADHD but then I was told that I shouldn't be making allowances for this (I: mhm) so (.) because I found it hard to maybe give him a punishing exercise cos I thought oh it's not his fault blah-blah-blah but then I was basically told that I should be (.) (I: right) treating him the same as everybody else (.) em cos I hadn't really had the experience or training with ADHD so em (.) didn't really give him a punishing exercise but I I maybe would I started to maybe to not give him as much attention (I: mhm) as before and to speak to him quietly outside (.) it did make a slight bit of difference but to be honest (.) not really and he was disruptive to the class not like a badly behaved badly behaved little boy (.) em but I thought he was like in a rut (I: um) and I felt that although (.) obviously he had had a problem he still got himself into a pattern of behaviour as well (I: mhm) which I thought it could be changed but I don't know how

From the above extracts, teacher subject positions are invoked in relation to the dilemma of the child's condition versus manipulated difficulties. In extract 7, the head teacher concludes that: "I I I wouldn't subscribe to the view that because a child had ADHD they are therefore unable to er (.) (laughs) control their behaviour and that they can (.) you know that they are therefore not accountable for their behaviour you know" (lines 9-12). From this construction, the child is to be held accountable for their behaviour despite a diagnosis of ADHD. Thus the teacher is required to enforce discipline. Such actions are conceded to result in

disagreements: “so sometimes that can cause a little bit of a er (.) misunderstanding with= (I: =oh yes) =parents” (lines 12-13). Clearly such “misunderstanding” with parents was echoed in the parental analysis which oriented to talk about competing versions of the child’s difficulties. This extract arose from an experienced head teacher. In extract 8, by contrast, a somewhat different construction is heard from an inexperienced class teacher with: “I used to make allowances because he had AD ADHD but then I was told that I shouldn’t be making allowances for this (I: mhm) so (.) because I found it hard to maybe give him a punishing exercise cos I thought oh it’s not his fault blah-blah-blah but then I was basically told that I should be (.) (I: right) treating him the same as everybody else” (lines 4-8). In this construction, the dilemma between “making allowances” for a condition versus treating the child “the same as everyone else” is apparent. This is heard against the orientation to authority (elsewhere this is probed by the interviewer to be the head of the department) with: “I was basically told that I should be (.) (I: right) treating him the same as everybody else”. In the following turn the teacher’s inexperience is invoked in relation to ADHD and is hearable with: “cos I hadn’t really had the experience or training with ADHD so em (.) didn’t really give him a punishing exercise but I I maybe would” (lines 8-10). Clearly such efforts at making allowances were superseded by normalising efforts within teaching which meant that the child’s behaviour should be accountable. In this extract, unlike “misunderstanding” with the parents, there was an orientation to the differences of opinion between the head of department and the subject specific teacher. The above extracts highlighted how teachers oriented to their own role and positioning towards children with ADHD. Differing constructions were explored from inexperienced and experienced teachers, but both were characterised by accounts in which differences of opinions were heard and which tended to be superseded by accountability. These dilemmas are further considered below.

Good teaching, experience and the ‘cases I know’ device in teacher talk

What was significant from the teacher analysis in chapter 7 was that it provides a valuable account of teacher’s constructions of children’s difficult behaviour and ADHD. In view of the limited work which has examined teachers’ discursive constructions, despite their day-to-day contact with such children, this is particularly relevant. The analysis demonstrated *how* it is that teachers in a UK context are able

to present alternative accounts for children's difficult behaviour in the face of the ever-increasing ADHD phenomenon. The analysis of the organisation of this talk showed how, through the use of the Not ADHD repertoire, teachers were strategically enabled to offer these alternative accounts and thus could be seen to be undermining medical constructions as ADHD. The use of the Not ADHD repertoire meant that teachers could successfully account for children's difficult behaviour in terms by which they were empowered as experts. This occurred through the 'cases I know' device whereby teachers accomplished expertise according to experiential knowledge and educational practice. This was evidenced in relation to teacher talk concerning: "*only* the cases that I know" (extract 5; chapter 7); "you know in a a number of cases" (extract 6, chapter 7); "with him" (extract 7, chapter 7) and "some of the cases" (extract 8; chapter 7). This was in contrast to a position of the non-expert for ADHD and appears against parental and health professional constructions of ADHD. Further, it is clear that the strategy was successful because, contrary to lay media and parent accounts that claim that teachers 'don't believe in ADHD', this work showed teacher accounts to be more complex. Clearly teachers in these accounts *did* orient to the ADHD repertoire (often as introduced by the interviewer), but it was the way in which they did so – through associations with an abstract entity that was entirely divorced from their experiential knowledge and through the lack of concrete explications – that meant the ADHD repertoire in these accounts could be superseded by the Not ADHD repertoire. Thus it is held that it was in this way that teachers could resist ADHD explanations for children's behaviour.

In addition to drawing on experiential knowledge in order to do not ADHD discursive work, teachers also attended to their own theoretical role in meeting the challenges associated with teaching ADHD pupils. The following lengthier extracts are produced which explore the skills and attributes required for this and can be regarded as the intersection of educational practices and medical knowledge.

Extract 9

Teacher Interview 6: Deputy Head teacher & Subject specific teacher of Harriston Primary

1 DHT: I think quite a lot of the em the strategies that we use with children with ADHD
2 (I: mhm) would be consider considered to be (.) **good teaching anyway** regardless

you know it would be just it's just you know *good teaching* (I: yes) em and would be suitable for *any* child you know whether they've got ADHD or not or whether or they've got any other kind of additional support needs or none at all (I: yes) it would just be considered to be (.) good teaching strategies it's an awareness really of the individuals within your class (I: yeah)
SST: yeah expectations and just (.) challenges basically […a few lines omitted] um trying to maintain the structure to the lesson and to the day (I: mhm) routine you know all children respond well to routine well especially at this time of the year it's hard to maintain (laughs) (I: laughs) em but yeah and clarity of purpose as well cos someone with ADHD have clarity of purpose=
DHT:=em sometimes short bursts of concentration expected and then allowing the child to go off and do something a little bit different just to get a little break from that and then maybe drawing then back in
SST: (fairly) rewards and sanctions as well (DHT: yeah) so you know if you do this work and you will receive the reward (you're gonna) […a few lines omitted]
DHT: but mainly I suppose it's about (.) dealing with children as individuals and finding out as the classroom teacher what works for that child (I: yes) em but also knowing that what worked yesterday (.) might not work today (I: yeah) you know so it's a lot of thinking on your feet basically (I: yeah) and em quite a lot a' negotiation with that child (I: mhm) em sometimes too much negotiation cos I think we bed over backwards (.) sometimes to to you know accommodate=
SST: =and the further we bend the further they'll push us
DHT: =children **and sometimes it's difficult to get the balance right** between what is that child manipulating and (I: um) and what is (.) are real genuine difficulties (I: yes um) so it's about again *knowing* the child (I: um)
SST: there's a difference between someone that *can't* and someone that *won't*

Extract 10

Teacher Interview 7: Deputy Head of Newville Primary

T: […] maybe making too many allowances (I: oh) and so you're getting (.) you kind of get in a muddle with (.) is it actually the syndrome (I: mhm) that's that's fully (.) the child's behaving in that way because of the syndrome or is is also (.) the syndrome plus the way we respond to it (I: yes) and you know and I think that way we can get a bit muddled up
I: um and do you think (.) is there a way round it for teachers
T: well that is that is difficult because obviously you do have (.) I think if you're responding to the individual and try to you know (.) we do (.) setting your boundaries (.) there may be (.) you may have different boundaries for different children and you will you know (.) and you will have different boundaries fr different children (.) but making sure that you are being consistent and that you are trying to respond to that whole child as that child is rather than saying oh well we better not we better not em (.) ask them to do this cos they might not like it or we better not you know obviously you're going to respond but just making sure that (.) the(.) what you're asking of the child that you're pretty confident that that child can achieve that or can do that and you're not then just making too many allowances for (.) for them because there's a syndrome

Extract 11

Teacher Interview 9: Learning support teacher of Newville Primary

[LT has been working up a list of strategies that she would offer to classroom teachers if they had a pupil with ADHD in the classroom]

I: I was just going to ask how would a teacher (.) do that in a class of thirty
T: well (.) some teachers are better at it then others but it takes quite a bit of experience and planning (I: um) er to think right (.) this doesn't need to be a written task (I: yes) this can be a discussion (.) or we can have a different outcome here or we can go about this in a different way um (.) but that that really takes (.) it's achievable (I: yes) and [local area] has done some training on learning styles and an awareness of the child also needs to have an awareness of how they like to learn best as well (I: yes) all these (.) factors come into play and (.) but there has been training of that (I: oh yes) they've been teaching about different learning styles and things

From the above extracts it is clear that there is a similar orientation to the qualities and skills required for such teaching with pupils diagnosed with ADHD. In extract 9 this is encapsulated by: "I think quite a lot of the em the strategies that we use with children with ADHD (I: mhm) would be consider considered to be (.) good teaching anyway regardless you know it would be just it's just you know *good teaching"* (lines 1-3). In this turn the deputy head teacher introduces the notion of "good teaching" which is repeated and emphasised (as highlighted above). The next turn is significant because such "good teaching" strategies are worked up and generalised to all children as seen with: "and would be suitable for *any* child you know whether they've got ADHD or not or whether or they've got any other kind of additional support needs or none at all (I: yes) it would just be considered to be (.) good teaching strategies" (lines 3-6). The definition of such "good teaching" is invoked further with the initiation of: "it's an awareness really of the individuals within your class" (lines 6-7). This serves to initiate a co-construction with the subject specific teacher regarding a definition of the teaching including such aspects as routine, structure, concentrated learning, rewards and sanctions etc. as seen in the later lines. In extract 10, a similar orientation is worked up by the deputy head teacher. Following the orientation to the "muddle", the interviewer had probed further with: "um and do you think (.) is there a way round it for teachers" (line 6). This precipitates talk about similar characteristics relating to such teaching with: "responding to the individual" (line 8) and "setting your boundaries" (line 8-9) for example. In extract 11, a similar orientation to the notion of good teaching is invoked by the learning support teacher when the interviewer probes: "I was just going to ask

how would a teacher (.) do that in a class of thirty" (line 1). This turn is initiated with: "well (.) some teachers are better at it then others but it takes quite a bit of experience and planning" (lines 2-3) which signals the individual skill and experience of the teacher as central in this regard and can be seen as invoking a similar orientation to such good teaching. Further aspects are generalised to include specific educational knowledge about different "learning styles". What is clear from these extracts here is how medical strategies about ADHD are minimised in favour of generic teaching strategies which would work with all children and which do not depend on diagnosis.

Educational guidelines and ADHD

An analysis of educational guidelines produced for ADHD in the UK was illuminating for the teacher analysis. Cooper and O' Regan's (2001) *Educating children with AD/HD: A teacher's manual* is particularly significant for the teacher analysis here. In the manual the authors referred to and discriminated between '*pseudo*' versus '*genuine*' ADHD in order to offer the teacher a means of identifying genuine ADHD (2001: 5). It is argued that the appearance of these distinctions in these guidelines bear a striking resemblance to the empirical analysis conducted here and the repertoires identified in teachers' talk about ADHD. Further reference to these educational guidelines is considered below:

> If the behaviours of concern can be directly associated with external stressors, then before the possibility of AD/HD is considered efforts must be made to remove these stressors, or, where appropriate, help the affected individual to learn effective ways of dealing with the stressors. If the behaviour difficulties are directly the result of external problems then it is unlikely that one is dealing with a case of AD/HD, but rather one is confronted with *Pseudo ADHD* (Hallowell & Ratey, 1995; cited in Cooper and O'Regan, 2001:6, emphasis added).

In addition, the characteristics of Pseudo AD/HD were defined as something that was deceptively like ADHD and was explicitly to do with: resembling AD/HD, were temporary and directly associated with situational or environmental factors, were not pervasive and common. It is clear that such discriminations in the manual occurred in teacher talk about the Not ADHD and it is significant that such a distinction was found in these accounts. The above discriminations were hearable from the data concerning teacher talk about 'poor' parenting explanations in the Not ADHD repertoire and clearly in these instances it was the parents that were construed as the "situational" or "external stressors". This was clearly apparent from the details of

the poor parenting explanations as seen in the above section. The implication being that as long as such 'pseudo' explanations exist in teaching manuals, then they provide frameworks for teachers, as in the Not ADHD repertoire, for alternative explanations to account for children's difficult behaviour as implicated by parental management. Although this means teachers could be seen to be empowered and experts in such constructions, it also implies that the origins for such difficulties can be placed on parents rather than constituted as within educational practices and school management issues as intimated above. Thus such ambiguities in educational guidelines were reflected in teacher talk about ADHD and Not ADHD and may reflect significant ambiguities within such educational contexts for medical diagnoses such as ADHD. Clearly such ambiguities relate to tensions within educational guidelines for ADHD which draw from developmental theories to emphasise environmental influences on childhood and yet also draw from medical knowledge as ADHD which specifies constitutional difficulties. Thus child-centred pedagogy and medical constructs require greater consideration in terms of their competing ideological implications within educational contexts.

Teachers versus Health Policy Guidelines for ADHD

What is further significant from the findings was how the teacher's lack of agency and expertise was associated with ADHD diagnoses in terms of classroom management but also in terms of the diagnostic process itself and in the health policy used for ADHD. Such teacher accounts and positioning as external agents to practices about ADHD, resembles previous literature in terms of exclusion from the NICE Guidelines for Methylphenidate (2000) (chapter 2) and by other researchers (i.e. Malacrida, 2004) who have argued that schools and teachers are the least likely to be considered collaborating professionals in ADHD. The empirical analysis of such positioning here supports this finding. In addition to everyday classroom management strategies, it has wider implications for the diagnosis of children with difficult behaviour more generally – in terms of their identification, assessment and treatments by outside agencies such as parents, health professionals and health policy. Clearly, teachers were positioned as powerless and passive in such processes as was demonstrated in such accounts oriented towards *misdiagnosis* and *mistreatment* whereby teachers' efforts were constituted as limited in relation to how children's difficulties were constituted. While Not ADHD discursive work may be seen as efforts to 'demedicalise' children's difficulties as ADHD (in Conrad's terms)

in order to achieve teacher expertise, it is clear that such efforts appeared limited in the analysis. Clearly teachers positioned themselves as largely external to such medicalisation processes in the UK, which is significant because this differs from findings reported in North America. Furthermore, it highlights the estrangement of teacher positioning in relation to medicalisation from health policy. Extract 9 from chapter 7 is reproduced from the head teacher along with two further extracts from a class teacher and learning support teacher to expand this further.

Extract 9; Chapter 7

Teacher Interview 4: Head Teacher of Greenwood Primary

T: […] and I think the most concerning thing is when we're given a (graph) to fill in the scale (.) it doesn't seem to matter what we say (I: ah right) whether or night the Ritalin is prescribed […] I now actually send in a cover letter whenever I fill one in (I: mhm) it goes (.) a letter goes with it with a fuller exploration of the child in class and how we find the child (I: yes) because the guidelines here are that (.) children have to display the symptoms if you like of ADHD in more than one context (I: yes) it seems to be (.) only the home context that counts (laugh) […] it's a very cynical outlook but our school community doctor agrees (laughs) I don't know if if you've heard this one before but you know the disability allowance (I: oh yes) which is automatically given to children who are diagnosed with ADHD and on Ritalin (I: right) and there's a (.) you know it does seem to have an influence on whether children are ADHD or not (laughs).

Extract 12

Teacher Interview 8: Class Teacher of Newville Primary

T: […] often we (.) get letters from the hospital to say can you fill in a form to check about this child's behaviour I mean we don't really know (.) we're not always involved in that process because (I: yes) sometimes the problems don't manifest themselves in school (.) (I: mhm) it's out with school and you know you're having to perhaps give a contradictory report to the parents (I: mhm) and then (.) it can be very difficult because if a child doesn't display (.) ADHD signs (I: mhm) in a classroom but is displaying (.) something at home (I: yes) then we have a discrepancy and there are a few cases that we've had to say well no (.) we don't agree with that
I: where you were surprised
T: yeah uh huh and in those cases I would think that it's (.) perhaps (.) (laugh) I feel bad now (.) it's perhaps um (.) a lack of boundaries at home lack of discipline and just perhaps not perhaps not knowing (.) you know how to follow through on what they say (I: yes) it's difficult and we can't say that for every case but you know (I: yeah) but for some cases I would think that if a child can sit still and concentrate in one area of their life then they're choosing not to do it (I: yes) in another

I: yes (.) and has that led to any difficulties with the parents if you're saying something contradictory to what they're saying
T: yeah I mean (.) we haven't had too many cases (I: yes) I can only think perhaps one or two but one wasn't an ADHD case one was another one (.) um which was an entirely different medical issue but we had to disagree with that as well we weren't seeing what was apparently being seen at home (I: oh yes) and you could take a very cynical view that em (.) there are benefits for children who have (.) some labels and sometimes (.) you know in this world that (.) it's perhaps parents are after the benefit that goes with the so called disability

Extract 13

Teacher Interview 9: Learning Support Teacher for Newville Primary

I: […] I was just wondering if there were areas of differences of opinion maybe like when parents submit a report and maybe when someone from the school
T: oh very much so (I: oh yes) yes er we used to do the (.) is the the one from Conner's Rating Scale
I: it could be the Conner's yes
T: yes yes I've done the Conner's Rating scale before (I: oh yes mhm) em (.) uh huh em (.) Conners Rating Scale yes our opinion has been different the school opinion has been different from the parent opinion (I: right) and I don't know who deals with the differences of opinion (I: yes) perhaps the paediatrician or something (I: yeah) but em (.) they were certainly different (I: yeah) absolutely
I: why do you think they were different
T: well (.) totally different environment for the child (I: yes) em (.) tends to be a (.) quite a quite a lot of structure quite a lot of routine and stuff at school (I: yes) that you don't get at home […]

The above extracts are concerned with talk about teacher involvement in medical diagnosis whereby teachers are required to complete a rating scale (often a Conner's Rating Scale as discussed in Chapter 4). Health guidelines (e.g. SIGN, 2001) require that symptoms are displayed in two contexts before a diagnosis is made based on DSM-IV (1994) criteria as discussed in Chapter 2. Against such policy, talk about the teacher's involvement in this process is hearable as problematic. In extract 9 from Chapter 7 this was noted in: "because the guidelines here are that (.) children have to display the symptoms if you like of ADHD in more than one context (I: yes) it seems to be (.) only the home context that counts (laugh)" (lines 5-7). In this instance the head teacher had displayed both a knowledge of ADHD guidelines and had problematised the practice because only the home context appeared to count, indicating that parents had undue influence on the process of diagnosis. Such motivations by parents were seen to be directly due to particular rewards: "I don't know if if you've heard this one before but you know

the disability allowance (I: oh yes) which is automatically given to children who are diagnosed with ADHD and on Ritalin (I: right) and there's a (.) you know it does seem to have an influence on whether children are ADHD or not (laughs)" (lines 8-12). A similar construction to claims of misdiagnosis and mistreatment was seen in extract 10 of chapter 7. In the additional extract 12, the class teacher orients to a similar construction and illustrates the complexities of the process when parents and teachers present contradictory reports of the child's behaviour as seen in: "we weren't seeing what was apparently being seen at home (I: oh yes) and you could take a very cynical view that em (.) there are benefits for children who have (.) some labels and sometimes (.) you know in this world that (.) it's perhaps parents are after the benefit that goes with the so called disability" (lines 20-24). Again, parental motivations for disability living allowance are made available as plausible explanations for the seeming contradictions in reports by parents and teachers. What is also significant about this extract is how the class teacher, resembling the head teacher's construction in extract 9, attends to the identity of the "cynical" teacher and to claims that teachers are biased. This is countered with: "(laugh) I feel bad now (.) it's perhaps um (.) a lack of boundaries at home lack of discipline and just perhaps not perhaps not knowing (.) you know how to follow through on what they say" (lines 10-13). In this turn, the class teacher displays trouble formulating the view that the parenting is at fault as seen in the laugh and preface of: "I feel bad now". This is effective in orienting to the teacher's own stake in making these attributions which, as was evident in parental talk, was clearly undermined by parents. Thus, "I feel bad" works to counter the notion that the teacher is being unreasonable in holding such parenting as responsible. The extract with the learning support teacher, however, works as a negative case analysis because an alternative construction for competing reports is hearable. In this extract 13, the interviewer had actively asked about the issue of competing reports as this had emerged from previous interviews. Unlike parental motivations for disability living allowance driving the reports, an alternative explanation is offered with: "well (.) totally different environment for the child (I: yes) em (.) tends to be a (.) quite a quite a lot of structure quite a lot of routine and stuff at school (I: yes) that you don't get at home" (lines 12-14). From this turn, it is natural that the reports would be different because of the different environments involved for the child. The school environment is regarded as more structured which may account for why the child behaves

differently. Thus, parental motivations are not considered key here. However, this aspect was directly pursued further by the interviewer with the following:

Extract 14

Teacher Interview 9: Class Teacher of Newville Primary

I: have you felt pressure from parents [when filling in reports about the child]
T: er yes yes you get forms and you get them coming in and saying things but it wouldn't make any difference to what I put down (I: yeah) but yes you do feel a bit of pressure (I: um) but you can often tell with people who are going to put in something different parents who are going to put in something different they would probably know (.) that parents are going to put something different in but it wouldn't make any it wouldn't influence (.) what I put in
I: your decision
T: no not at all
I: but sometimes you felt that they wanted you to say (.)
T: oh yes oh yes absolutely uh huh
I: oh (.) how would they exhibit that pressure
T: well I was more accessible at my other school cos it was a smaller school (I: yeah) so quite often I built up a good relationship with parents but they would come in and say 'I want (.) could you fill this form in for me' or at the last minute and 'I need it tomorrow' (laughs) or 'I need it' and you know 'I want you know I want to hand this in to the doctor whoever and I need to cos I think he's got ADHD' and (I: um) but they wouldn't mention the living allowance but (I: yes) but they would (.) you know there would be a rush on it (I: yeah) and they might you know make a little comment about (.) needing it […]

In the above extract, the learning support teacher in response to the interviewer's probe about pressure from parents, states: "er yes yes you get forms and you get them coming in and saying things but it wouldn't make any difference to what I put down (I: yeah) but yes you do feel a bit of pressure" (lines 2-4). Here the teacher orients to her own role in the writing of forms with: "but it wouldn't make any difference to what I put down" (lines 2-3) which attends to her own accountability in writing these reports. The notion that the teacher may be influenced by the writing of reports and secede to parental demands is attended to and countered here. This is repeated later for emphasis with: "in but it wouldn't make any it wouldn't influence (.) what I put in (I: your decision) no not at all" (lines 6-9). From these extracts, while explanations differed to account for discrepancies for parent and teacher reports, the notion that parental motivations for disability living allowance were influential in such reports was made available. Against this, the school was heard as not unduly influenced by such factors and these constructions appear against current health policy guidelines for ADHD.

Finally, the findings here will be considered in relation to the limited research that has been done in the area with teachers. Conrad's (1976/2006) early findings indicated that teachers were central and influential in terms of identifying difficulties as ADHD and that they exerted pressure on parents about such difficulties. Rafalovich's (2004) recent findings largely supported those early findings. In his work, teachers were proactive and engaged in a 'semi-formal suspicion' of difficulties. They had considerable knowledge about ADHD. In addition, Malacrida's (2004) work indicated that parents' perceptions of teachers in the UK regarded teachers as largely resisting the medicalisation of children's difficulties as ADHD. They were less likely to seek to identify such children with difficulties as ADHD and less likely to consider medications necessary. This was in contrast to Canada where teachers were seen as 'pushing' for the identification of ADHD and treatment with medication. However, Malacrida's (2004) work did not actually focus on teacher accounts. The findings here provide a significant contribution to the understanding of teachers and ADHD in the UK. The work provides empirical support for teacher efforts in talk that sought to actively de-label or provide non-medical explanations for children's difficult behaviour. In resisting such medical explanation, teachers resisted medical diagnosis and treatment in favour of accounts which produced instances of misdiagnosis and mistreatment. These accounts worked to invoke teacher accountability and agency into children's behaviour which had been disempowered through ADHD diagnoses. Thus accounts functioned to restore and accomplish teacher agency into explanations for children's behaviour. This is a clearly different scenario to findings that have been conducted amongst teachers in a North American context and is thus in contrast with Rafalovich's (2004) findings. For example, teachers did not appear to be involved in the increasing identification of difficulties as ADHD or actively involved in the medicalisation process (i.e. such 'semi-formal suspicion').

Conclusion

This chapter has been concerned with further consideration of the insights obtained from parental and teacher talk from chapters 6 and 7 in order to extend the analysis to parental and teacher discursive positioning in ADHD talk. The further exploration of the findings from the parent analysis highlighted how parents drew from the opposing biological and environmental repertoires which appeared incompatible with a biopsychosocial model of ADHD and which centred on genetic explanations and

parenting issues. Further analysis of the 'good parent' device, which occurred in parental talk in order to attend to moral adequacy, highlighted that this device occurred in both joint interviews as well as maternal and paternal interviews and is thus not purely a maternal feature. It also showed the pervasiveness of parental blame (i.e. where being *too strict* or *not strict enough* was a feature and indicates the Foucauldian gaze by parents on to their own parenting practices). Parental talk used specialist ADHD knowledge in order to achieve credibility for the condition and the use of ADHD as a disease metaphor was a persistent discursive feature which worked in order to build credibility for ADHD as a biological condition more generally. The analysis of a negative case analysis in relation to parental subject positions and medication, highlighted that although a more positive construction of the use of the medication was achieved, that overall the narrative was similarly concerned with an identity construction of the 'good' parenting. In the teacher analysis, the use of the ADHD repertoire and the Not ADHD repertoire was considered in relation to the data collection method. Further exploration of the Not ADHD repertoire highlighted that while teachers drew on educational and environmental theories for children's difficulties as opposed to medical constructions, the emphasis was largely on early corruptive parenting influences rather than wider influences. Teachers worked to constitute children's difficulties as "poor parenting" in reductionistic terms which meant that schools avoided accountability for difficulties in environmental explanations. In addition, further exploration of teacher subject positions highlighted how the 'good teaching' strategies were tied to experiential knowledge and generalised teaching methods rather than specialised strategies for ADHD pupils. Teacher talk was considered in relation to wider educational guidelines for ADHD in order to highlight how such talk reflected ambiguities within such guidelines more generally in terms of educational discourse and medical knowledge. Finally, health policy guidelines for ADHD, as seen in SIGN (2001), were juxtaposed with teacher talk which elaborated instances about contradictions in report writing and about parental motivations for diagnoses which could be heard as further instances of (mis)diagnosis and (mis)treatment.

Chapter 9: Discussion

Introduction

The present chapter is a discussion of the overall findings of the thesis in light of the analytic chapters 6, 7 and 8 which came from parental and teacher talk about ADHD. The chapter also consists of a reflective discussion of the strengths and limits of the methodological approach used, in order to situate the work within current methodological debates. In addition, suggestions for future research in the area of ADHD are made. Finally, the main contributions of the thesis are summarised.

Overall implications for Parents, Teachers and ADHD

The analysis conducted here was an in-depth investigation of the culturally available ways of talking about ADHD in an area of Scotland for parents and teachers, in view of the widespread diagnosis and treatment of ADHD in this specific area. Analysis of interview data obtained from this area, suggested that there were a number of similarities and differences between the parent and teacher accounts. Perhaps the biggest similarity in the accounts was related to the findings that both parents and teachers similarly oriented to parental accountability and responsibility for the child's difficulties. However, these orientations towards parental accountability occurred in different ways. In parental talk such accounts were organised to attend to issues of moral adequacy and 'good' parenting in relation to the Biological and Environmental repertoires which were seen to underlie biopsychosocial models of ADHD. In teacher talk, by contrast, such parental accountability for children's difficulties featured as an alternative explanation to medical explanations of ADHD. This was evidence that this was clearly a sensitive topic for teachers to initiate. The main differences relating to the organisation of the accounts for parents and teachers was over the use of the medical explanations for the difficulties. Through the 'good parent' device, parental accounts sought to constitute such difficulties as due to biological or genetic explanations as primarily accountable for difficulties. Teacher accounts were hearable as orienting to such medical explanations, but as highlighted above, the way in which they did so (i.e. as an abstract entity divorced from experiential knowledge) meant that Not ADHD explanations prevailed in talk about children who had received a diagnosis of ADHD. Thus further orientation to

misdiagnosis and mistreatment was heard as an illustration of teacher disempowerment and estrangement in talk about current health policy for ADHD. The analysis of such differences within parental and teacher accounts suggests that as wider use of DSM-IV criteria for ADHD occur in local areas in order to 'identify' children as ADHD, competing versions and explanations to ADHD will be increasingly difficult to maintain. The alignment of parental accounts, with such expert and specialist knowledge about ADHD, positions teachers precariously in relation to their own status and knowledge as experts of children's behaviour.

Strengths and Limits of the Present Study

In addition, there are a number of methodological strengths and limits with the present study which will be considered in relation to the present study.

'Critical discursive psychology' as an approach in ADHD

The analysis conducted in this study offered an innovative approach in the area of ADHD research in terms of studying talk about the topic of ADHD and the limits and constraints of this talk in a local area in Scotland. From a discourse analytic perspective, talk about ADHD is important because of how it constitutes experience. An eclectic approach that utilised the framework by Edley (2001) provided a useful means of approaching this analysis. As highlighted in chapter 5, there were a number of advantages in using an eclectic version of discourse analysis. These benefits included the use of the conversation analytic principle of grounding claims in participant orientations and focusing on everyday talk as significant. In addition, an interpretive account was tied to the broader historical and socio-cultural context in which ADHD arises. The eclectic version of discourse analysis also provided a useful means of understanding ADHD talk in terms of how such current contexts follow medical frameworks for children's behavioural difficulties, while at the same time offering a focus on individual, localised accounts for ADHD as a topic, in order to offer greater understanding of what this talk allows and constrains for those confronted with ADHD. Previous discursive research in ADHD has similarly made use of eclectic approaches (i.e. McHoul and Rapley's (2006) conversation analysis with critical discourse analysis; Malacrida's work (2001; 2003; 2004) utilised Foucauldian discourse analysis with Feminist analysis for both an inductive and

deductive approach). While the research area ultimately defines the most appropriate approach, clearly the eclectic approach was adopted in order to overcome various limitations associated with specific approaches in discourse analysis. The use of the 'Critical Discursive Psychology' approach in the present study as applied to the field of ADHD adds a valuable dimension to critical ADHD approaches and to methodological debates in discourse analysis.

This study appears within the discourse analytic field in the context of wider methodological debates over the most appropriate means of analysis. In the area of current conversation analysis, others have not been convinced about the benefits of the eclectic version of discourse analysis (e.g. Schegloff, 1998; Wooffitt, 2005). For example, Wooffitt (2005) made a persuasive case for the use of conversation analysis and echoed prior arguments for such analysis (e.g. Schegloff, 1998; Widdicombe and Wooffitt, 1995). Such arguments are critical of 'top-down' approaches in discourse analysis that are theoretically informed. The critique is essentially based on: neglecting the social interactional context of the data, particularly in interview data; a reductionist view of human conduct; the slide into 'ascriptivism' and an inconsistent methodological basis. These points will be considered in relation to the present study as well as for the broader methodological debate in which it occurs.

It is recognised that the data generated for this study was both enabled and constrained by the research interview. The research interview is not a natural setting but is by definition constructed in order to follow a research agenda. The processes of recruitment, consent, information, recording etc. marks them as research oriented. Despite efforts to encourage easy and informal dialogue by the researcher, for example by conducting interviews in parent homes or at schools, ultimately this is a research interview. It is recognised further that participants, including the interviewer, may have been attending to the interactional features of the research interview setting. Such features may have included, for example, question and answer turn-taking in which the interviewer is acknowledged to ask questions while the participants provide answers rather than questions. In addition to this interactional setting, other features may have been relevant which necessarily received limited attention in this study due to the focus on a mixed approach. However, attention has been paid in this analysis to interviewer questioning as part of the interactional exchange between participants and interviewer. The role of this questioning has, where it was deemed relevant, been considered as part of the

organisation of such talk. For example, in chapter 7 the teacher analysis highlighted the ADHD repertoire and Not ADHD repertoire as a possible feature of the research design and interaction. Here the introduction of 'ADHD' was driven by the research agenda as introduced by the interviewer. Such orientation and subsequent departure from the topic of ADHD was noted in teacher talk. However, the justification for the introduction of ADHD as a topic was in order to examine talk about this increasing topic in a previously neglected sample. In addition, how teachers oriented to the topic was itself considered a feature significant in the analysis.

In addition the identification of interpretive repertoires and subject positions have been accused of offering a reductionist or 'shallow' view of human conduct because of the tendency to reduce such claims to a limited number of repertoires or discourses (Wooffitt, 2005: 179). This is in comparison to a focus on the interactional features of talk from a conversation analytic approach which recognises the complexities of the discourse. It is argued, however, that the level of detail required for a rich and full analysis of human conduct is itself open to debate. By implication, the exclusive focus on the interactional features of talk means that wider cultural aspects necessarily receive limited attention in such exclusive focus of talk-in-interaction at the expense of contextual interpretations. This has itself been the subject of critique against the conversation analytic approach (e.g. Wetherell, 1998; Billig, 1999b). Thus Wooffitt's charge appears unfair. The value of critical approaches to discourse may be with their pragmatic value and potential to critically engage directly with prevailing practices in society. In addition, such interpretations may have the potential for providing understandings of previous unexplored areas of human conduct and experience. For example, Gillies (1999) examination of the discursive positioning of women smoker's offered an interpretation for the failure of smoking cessation practices amongst this target group. In the present study, the discursive positioning of parents and teachers in talk about ADHD highlighted disempowering effects inherent in such health policy. Following the broader goal of the qualitative research enquiry more generally, it may be argued that any analytic endeavour necessarily implies that some aspects receive greater attention while others are limited, depending on the approach adopted. This is true for the interactional approach.

An eclectic version of discourse analysis, such as the one adopted here, enables that analytic attention is paid to the empirical data while at the same time

utilises the wider context of such data. This feature is common to much qualitative research and relates to the researchers' reflexivity or transparency in the analysis. The conversation analytic focus on participants' orientation is an attempt to ground analytic claims in order that such claims do not result in 'ascriptivism' or imposing the theoretical interests of the analyst (Widdicombe and Wooffitt, 1995). However, the limits with sole focus on such features is also recognised in that such fine-detailed focus means that the wider context is necessarily neglected at the expense of such interactional features (Wetherell, 1998). Billig (1999a) has also maintained the failure of such fine-grained analysis to recognise that the conversation analytic principles rely on the imposition of a previously generated analytic framework, despite claims to the contrary. Here it is recognised, that any analysis necessarily implies the use of analytic concepts which are imposed and applied to the data. Thus notions of a reflexive account in which the researcher demonstrates the rationale for such choices may be called for. Similarly, in interpretive analysis, it may be pragmatic to offer this interpretation in a transparent manner. Thus Edley's (2001) analytic framework was seen as useful in the field of discourse analysis as a means of overcoming such polarities in the field in order to offer an interpretive analysis of lay talk about ADHD in relation to professional constructions in health policy.

It is argued following others, that such methodological disputes in the field of discourse analysis create unhelpful polarities (Wetherell, 1998; Gwyn, 2002). The either/or dichotomy between the relevance of fine-detailed analysis versus the broader context is *itself* problematic in its failure to recognise the complexity of human life and the interrelationship between an individual user of language and the broader social context which enables such language in the first place (Billig,1991; Edley, 2001). In the field of ADHD and in the UK, parents and teachers did not invent the term 'ADHD'. It has recently appeared with increasing frequency in this context and circulated through medical use, information technology and the media as well as everyday use. Theoretical concepts in sociology have provided a useful framework about the medicalisation of deviant behaviour as an alternative to the medical explanation. Such an approach has highlighted the historical and cultural emergence of this construct as well as social practices in institutions and clinical practice which construct ADHD. However, insights from ethnomethodology and conversation analysis recognise the importance of ordinary, everyday talk. It is also a site where ADHD as health policy is constructed and negotiated. Analysis of this

everyday level is important to inform how lay people such as parents and teachers take up and make use of controversial medical terms like ADHD. Attention to the interwoven nature of the language user and the cultural context is important for a rich understanding of ADHD and this is the novel claim of this thesis although it is recognised that these disparities in discourse analysis may not readily be resolved in the field (e.g. recently Edley and Wetherell (forthcoming) have replied to a critique of the eclectic method in the area of gender, and have re-iterated their own claims for a mixed approach for this topic).

Finally, Wooffitt's (2005) critique appeared as a means of emphasising the benefits of conversation analysis over other approaches, as mentioned above. His own formulation of: 'How should we analyse talk' presupposes that there is one way, a correct way of analysing talk. This has been recognised by critics as a form of positivism because it forecloses other possibilities in the field. It has far-reaching implications in terms of prescribing the type of transcription conventions (i.e. Jeffersonian) and the type of data collection to be used (i.e. naturalistic) (Potter and Hepburn, 2005). This work, in keeping with others, rejects such positivistic connotations for the field both for the methodology adopted, transcription and data collection as clearly unsatisfactory in its attempt to be regarded as the most valid approach for studying talk. Instead, it is argued that a multiplicity of approaches should be recognised for the study of talk and for the potential that they may offer to this topic.

On this last point, it is recognised that an interpretative discourse analysis, following qualitative enquiry more generally, has a number of challenges in terms of issues to do with defining 'quality'. A recognition of the diversity of approaches in qualitative research and discourse analysis particularly, requires that other criteria be adopted for assessment of scholarship such as persuasiveness, coherence, quality of analysis for example (Wetherell, 1998; Yardley, 2000; Taylor, 2001; Dixon-Woods et al, 2006). In chapter 5 it was maintained that a transparent account was important in order to encourage reflexivity and to be explicit about the research processes adopted. This was consistent with the 'Critical Discursive Psychology' approach which offers an interpretive analysis. Assessment of such aspects as 'quality of analysis' is, however, a less tangible area for discourse analysis than alternative means of assessment in other areas of qualitative analysis such as in grounded-theory's triangulation or respondent validation. These are complex issues which are recognised here. Finally, in addition to these epistemological issues

relating to the study, there are a number of methodological limits for the study which will be addressed.

Simplified transcription conventions

It is conceded here that the use of standardised and detailed conventions such as the one developed by Jefferson (Atkinson and Heritage, 1984) has its advantages. Such advantages include the use of a widely recognised and developed system, and an inclusive system that reflects a range of important features found to be significant in talk. This is important for fine-grained analyses which aim to examine the sequences and the details of talk. Critique from a conversation analytic perspective, and increasingly within discursive psychology, regard the use of the simplified transcription conventions as a limitation. Such critique centres on the loss of detail that is omitted when this 'lite' transcription process is used. However, some disadvantages with the full method, in line with others, are the somewhat obscure conventions to those outside the field and because they are arguably designed for a specific form of analysis (i.e. fine-grained and micro analysis). Thus, in keeping with others, it is maintained that these conventions were not appropriate for the analysis adopted here (e.g. Smith, 2005; Holloway, 2005). However it is recognised that this remains a highly topical area in contemporary discourse analysis with some arguing for the greater adoption for these conventions regardless of the type of analysis (e.g. Potter and Hepburn, 2005). Again, while such a position is unlikely to be resolved entirely, it is regarded as important to justify the position taken.

The semi-structured interview

There has been recent debate over the widespread use in psychology of the semi-structured interview as compared with naturally occurring data (e.g. Griffin, 2007; Henwood, 2007; Potter and Hepburn, 2005; 2007). The reliance on interviews in this study and the pragmatic value of the semi-structured interview for this study was already outlined in chapter 5. As well as providing accessibility and control to the researcher, of participants talk, the semi-structured interview allows a means of in-depth data-gathering in qualitative research. For a discourse analysis, the semi-structured interview was a useful means of studying lay talk as this talk could be

recorded and transcribed according to relevant transcription conventions. As highlighted above, however, criticism over the semi-structured interviews has highlighted that there may be other data more appropriate for analysis. In the area of discourse analysis particularly, there is a growing preference for naturally-occurring data, following conventions in conversation analysis. This work does not dispute the benefits of naturally occurring data for a discourse analysis or the potential for studying everyday institutional talk about ADHD (i.e. school review meetings; consultations with doctors etc.). Data obtained from research interviews, despite attempts to allow a conversational atmosphere to the research and conducting interviews in participants' own homes or place of work can not be considered to represent naturalistic talk in this regard, as mentioned above. This is acknowledged as a limitation in the present study. Again, as with any method of data collection, the strengths and limits of such methods should be recognised.

The Sample

Recruitment from a holistic charity

The sample of participants was considered in terms of the theoretical constructs relevant to the literature in ADHD, as highlighted in chapter 5. However, it is acknowledged that this sample relied on volunteers and was therefore limited in terms of control of the sample. A further consideration relates to the sample homogeneity in terms of recruitment from a single source, the holistic charity in the local area. Parents of a holistic charity may not be representative of the general population of parents with children diagnosed with ADHD and thus their talk may have been specific to this population. There are a number of points to be made in relation to this issue. Firstly, other literature in ADHD has highlighted the widespread use of alternative and complementary approaches for parents with children with ADHD (e.g. Bussing et al, 2002). Thus such parents are more likely than parents of children with general difficulties to use such treatments. In view of widespread use of such approaches then, parents from a holistic charity are less likely to be considered a specific and unique group of parents with children with ADHD. Considering that the majority of the parents in this sample used such treatments in conjunction to standard medical approaches further supports this finding. A second consideration is that this work concerns an analysis of the talk of a relatively small sample of parents and teachers and therefore can not be considered representative.

It is argued in relation to the above points that this work does not claim generalisability for the study; however, the analysis conducted points to an illustration of the patterns of talk available in this context. It does not claim that other ways of talking about ADHD were not available or to have 'captured' this talk absolutely. Thus the analysis presented does not rely on sample representativeness as a defining feature necessary for a quality analysis but rather depends on the coherence and persuasiveness of the analysis.

A 'lay' focus

In addition, this work was concerned broadly with the area of lay and professional constructions of ADHD. Health policy such as SIGN (2001) defines children's behaviour and seeks to classify such behaviour according to DSM-IV or ICD-10 criteria so that a medical conceptualisation is enacted. This work, while exploring the professional conceptions of ADHD in chapter 2, has clearly privileged lay constructions by the attention it has given these accounts in the analysis. The distinction between 'lay' and 'professional' has been adopted here as a pragmatic means of distinguishing between professional guidelines from lay parents and teachers who enact and produce such guidelines in everyday talk. It is recognised that such distinctions may be problematic. Others have taken issue over the use of terms such as 'lay' and 'professional' in the area of health and illness (e.g. Shaw, 2002). In addition, the emergence of the 'expert' patient in relation to knowledge, information, access and rights has been recognised (e.g. Prior, 2003). There was certainly this sense in relation to parental accounts that appeared as more 'knowledgeable' in relation to others such as teachers or extended families about ADHD. However, the term and distinction was used here as a pragmatic means of analysing and distinguishing between such lay accounts and appropriations of medical terminology.

Maternal Focus

In chapter 3 the argument was made that the tendency for qualitative research to focus on mothers' experiences at the expense of others was a general limitation in the research. Further a maternal focus tended to reinforce such contemporary assumptions of individualism which see the mother as ultimately responsible for the

child's health and well-being, and to blame for any deviations to the norm. Feminist writers have made a significant contribution in the area of ADHD. However, the present study included fathers as participants as well as teachers in an effort to consider the accounts of other groups who have day-to-day contact with ADHD and who have been neglected in the research. It is acknowledged that pragmatic issues with recruiting fathers meant that only a limited number of fathers were included in the study – four – in comparison to the mothers – eight. It is maintained here that it is important to include paternal and educators' accounts of ADHD because the identification of children with difficulties and their subsequent care does not occur in a vacuum. Schooling and fathering occurs alongside and interwoven with maternal care and is thus important. In addition, some of the interviews included joint interviews with both parents present or with two teachers, analysis of these interviews served to supplement the individual interviews. Such joint interviews highlighted how parenting or teaching accounts were engaged in co-constructions about ADHD.

Ethical considerations

This research, as noted in chapter 5, was reflexive in the sense that it considered parental experiences of the research process. This occurred when parents were asked about their experiences of taking part in a research interview about this topic. The rationale for this was not to build notions of 'credibility' or respondent validation for the research. Instead, the purpose rested on ethical issues about the inclusion of a potentially vulnerable population in a research interview. However, it is recognised that this is a problematic area. Namely, that the taking at face value of what parents had to say about being included in a research interview appears in distinct contrast to the discourse analytic approach of looking at the function and patterns of talk elsewhere in the analysis. In retrospect then, this question worked for its closing function in the interviews. However, ultimately it was recognised as incompatible with the overall methodology adopted in the study. Thus it was noted that most parent participants reflected positively on their participation in a research study in order to discuss this area, a few parents reported that they struggled to express themselves at times. However, the use and applicability of this question was limited in this work. Ultimately ethical considerations justified its inclusion and departure from the overall methodology.

Future directions

Future research about ADHD talk should be conducted in a UK context as this is an area increasing where ADHD may occur with increased frequency. The study used a sample of parents and teachers in order to consider such talk in relation to the broader professional guidelines which currently exist. Such guidelines are themselves not fixed but changing in relation to new conceptualisations and thus future research is required to consider how such changes of SIGN and NICE relate to ADHD talk as 2008 represents changing definitions of the guidelines. The recent MTA results which demonstrated the limitations of medication approaches over behavioural approaches in the long-term may also have greater implications for guidelines and changing cultural contexts which will result in changing ways of talking about this topic. Further work is required, from a critical perspective, in order to study the limits and possibilities which a diagnosis affords lay parents and teachers. Although it was not possible to study children's talk in this analysis in view of the very young ages of the children, it may be important to include teenage accounts of their difficulties to add a further valuable dimension to this topic. There is further research needed in relation to father accounts as well as teacher accounts, and other neglected areas such as general practitioners. For example, fathers' talk similarly oriented to parental accountability for the child's difficulties in this analysis and requires further attention. In addition, how such talk occurs in interactional contexts such as school review meetings or medical consultations is an important area of investigation for the identification of these repertoires and ideological dilemmas.

Summary of the Main Contributions of the Thesis

The originality and contribution of the present work rests on a number of separate but interrelated areas. These will be addressed below.

An argument for (re)considering ADHD

The thesis outlined the vast literature on ADHD and highlighted limitations of epistemology with the dominant approaches of the biomedical and biopsychosocial constructions, as well as for alternative and complementary approaches. This rested

on maintaining a form of biological reductionism in ADHD (in chapter 2). The argument was made for (re)considering the notion of ADHD as an organic abnormality, in favour of an approach which took a critical approach to ADHD. Such an approach has the benefit of a critical examination of the underlying assumptions of current ADHD definitions. The absence of an organic pathology, together with an increasing general biomedical acceptance of the ADHD phenomenon as reflected in current guidelines and diagnostic criteria, warrant a critical (re)examination of the construct of ADHD.

A Synthesis of the previously neglected area of Parental Subjective Experience and ADHD

In chapter 3, the research literature on the neglected area of parental subjective experiences and ADHD was reviewed according to the similarities and differences of the findings from the empirical studies. This review constituted a qualitative review and thematic synthesis of a previously unexplored area. While Nelson's (2002) metasynthesis explored mothering other-than-normal children from a range of different conditions, the present review concerned the single condition of ADHD. This review used empirical published research from a range of cultural contexts in order to provide greater understandings of the area of parental experiences. Considering the rising incidences of diagnoses expected globally for ADHD, this topic is relevant and topical. The review highlighted that: differences of opinions (largely by mothers), blame and responsibility, struggles, parental emotional distress and medication dilemmas were common themes reported in these studies for ADHD. Epistemological and methodological limits with the studies were also outlined according to the underlying humanist and interpretive epistemology, which placed the emphasis on individual subjective experience.

A New interpretation of the field of Critical approaches to ADHD

In chapter 4, the field of critical approaches to ADHD was espoused according to social constructionist assumptions. These various contributions to the field included: a critique of the individual pathology model from the biomedical model and as implied from child development theories; attention to the unique social influences and historical emergence of 'ADHD' in the USA with the 'discovery' of

psychostimulant medication effects; institutional and clinical practices of ADHD which produce ADHD, as well as attention to social processes of ADHD in everyday language. A new interpretation was outlined which recommended the use of a discourse analysis which appreciated the interwoven nature of the individual language user and the cultural context in which they reside, for producing ADHD talk. This type of approach was able to transcend traditional dualist conceptions in ADHD research. Such approaches tended to either privilege the individual pathology model (as highlighted in chapter 2) or alternatively turned to broad social and historical aspects as they impacted on the individual (highlighted in chapter 4). In approaches which did focus on social processes in ADHD, it was argued that a form of dualism was maintained in discursive studies. This occurred with the tendency to privilege the broader social and historical effects of discourses in ADHD at the expense of the individual speaker, or alternatively, focus on micro aspects of talk at the expense of the broader social context in which such talk was made possible in the first place.

The use of a 'Critical Discursive Psychology' methodology in the field of ADHD

Chapter 5 offered an original use of the 'critical discursive psychological' approach (Edley, 2001) as applied to the area of ADHD. Having originally been used in the area of gender and masculinity in order to explore the broader ideological influences and to empirical data about constituting masculinity (e.g. Wetherell and Edley, 1999), an eclectic version of discourse analysis was applied to the field of ADHD because of its potential to offer a rich analysis. Edley's (2001) analytic framework for an eclectic discourse analysis was useful for the area of ADHD because the analysis was inductive with the focus on empirically demonstrable features of talk, but it also offered interpretations of these orientations for subject positions and ideological dilemmas. In view of the current methodological debate and polarity in the field of discourse analysis, this work provides a further applied use of this method as adapted for the present purposes and further proposes the pragmatic value of this method, following Edley and Wetherell (forthcoming).

A Novel Empirical analysis of Parent and Teacher talk about ADHD

The empirical analysis of the thesis is a novel investigation of parental and teacher talk in a relatively neglected context – in a health authority in Scotland, UK. Teacher talk about ADHD has not been the subject of previous investigation and in the area of ADHD more generally, has been shown to be a neglected area. This was highlighted previously by Malacrida (2004) where teachers in the UK were shown to have a relatively ambiguous position in the UK for ADHD because, whilst having the greatest day-to-day contact, they were the least likely to be treated as collaborating professionals. Norris and Lloyd (2000) also highlighted how low teacher expertise was ranked for ADHD in media reporting. While parental experiences of ADHD have been studied previously in a limited capacity (mostly mothers), parental talk about this topic has received very little study. The main thesis has been to highlight the significance of talk as a social process worthy of investigation because of the central role that it plays both as a cultural resource, and as a tool that is able to be utilised by individual speakers in order to constitute experience. The analysis sheds valuable understandings of the range of subject positions available for parents and teachers in ADHD talk from a particular cultural context.

A 'Micro' focus on Medicalisation

Theoretically, this work has also contributed to providing an empirical analysis of the sociological process of medicalisation. However, this has not been as an all encompassing, broad theoretical concept, but rather as a local process which is enacted in everyday instances of parental and teacher talk about this topic. An important aspect of the medicalisation process, highlighted by previous theorists (i.e. Conrad, 1976/2006; Lupton, 1997), is the analysis of how lay collusion and appropriation of such processes occurs. The context of the UK was a useful one in which to examine talk about ADHD in view of the current status of ADHD as an 'incompletely medicalised' phenomenon. In view of increasing diagnoses and the central role of parents and teachers in the diagnostic process for ADHD, this provides a valuable understanding of how such talk is used in local contexts characterised by 'incomplete medicalisation'.

A Contextual approach in the field of ADHD

Within the context of the previous literature on ADHD, this work offers a contextual consideration of the field by considering maternal, paternal and educator accounts about ADHD. Such a contextual approach moves beyond the maternal focus, as seen in chapter 3, where maternal experiences were privileged over other perspectives. In addition, this is an attempt to move beyond such individualistic reductionism as rooted in child developmental theories and individual pathology models. It was argued previously that feminist contributions in the area of ADHD were valuable from a critical perspective, but they contributed ultimately to a reification of the focus on the mother at the expense of other significant groups. Hence this work is a contribution towards a contextual approach to ADHD with a focus on other significant carers of children with difficult behaviour.

Contribution to Critical approaches in ADHD

In addition, the entire thesis (chapters 4-8) adopts a critical stance towards the construct and growing use of the 'ADHD' construct. Thus this work serves to extend and contribute further arguments for a revised examination of the construct in the general area of critical ADHD. Such work is timely and topical in view of the current status of the construct and appears at recently published critique of ADHD in a UK context (e.g. Timimi, 2005; Lloyd et al., 2006). The current focus on a UK context is important as mentioned above because in Conrad's terms, the increasing medicalisation of children's behaviour in the UK is a recent and contemporary phenomenon and provides a fertile opportunity to study and critique this process. The empirical analysis and interpretation conducted here offers a further dimension in the area of critical approaches to ADHD.

Conclusion

This chapter has considered the overall findings from the parent and teacher analysis. The findings have generated understandings of parental and teacher social practices about ADHD talk in an area of Scotland and have considered the social and psychological implications for parents and teachers. A critical discursive psychological approach was useful in which to frame the analysis in order to engage

with prevailing practices for ADHD. The unique contributions of this work were summarised here. In the final chapter that follows, the implications of the findings in relation to current health and educational policy are discussed with recommendations.

Chapter 10: Conclusions and Recommendations

Introduction

The previous chapter was concerned with summarising the main findings from the parent and teacher analysis and discussing the implications of these findings. The chapter also considered the strengths and limitations of the present study, areas for future enquiry as well as the main contributions of the thesis. In the present chapter, the implications and recommendations of this work for current health and educational ADHD policy and practice, and for critical approaches to ADHD will be developed.

Implications for Current Health Policy and Practice of ADHD

The benefit of the present analysis for ADHD is that it yields valuable understandings of how lay parents and teachers socially produce talk about ADHD from a particular area in Scotland. This innovative focus on how current health policy, which defines children's difficult behaviour as ADHD in the first place, is taken up in novel ways by such parents and teachers in talk about such children. While health guidelines for ADHD aim to set objective and clear criteria for ADHD, both parents' and teachers' talk oriented to such definitions as problematic and contradictory as was highlighted in this analysis. The findings have highlighted the limits of an ADHD diagnosis in terms of the subject positions available for teachers and parents through talk about ADHD which centred on individual responsibility and management. Parental accountability for children with such difficulties and individuo-centred responsibility for it by parents and teachers are limited to such internal responsibility. In view of the rising incidences of ADHD, globally, and specifically in a UK context, the work calls for a critical revision of the appropriateness of this diagnosis. That parents and teachers were ultimately limited and disempowered in terms of talk about ADHD through individuo-centred blaming and estrangement from health policy, means that further critical work should be conducted to explore and extend the findings here. The social and psychological implications of such discursive positioning in talk are significant for how current health policy and practice of ADHD is developed in view of how it impacts and translates to such experiences.

In relation to the above, this work appears timely in terms of the current focus on health policy for ADHD. Quality Improvement Scotland's focus since the publication of the Health Indictors report in 2004 was on service profiling of the different health areas in Scotland (2007) and the second stage is an investigation of the SIGN implementation across the health areas as well as a report of parent and child views (to be released in 2008). This research coincides with these publications in the area of ADHD in Scotland and is a valuable addition in terms of understandings of the intersection between such health policy and everyday negotiations of such policy by those that are most affected. This work may have the potential to influence debate about policy (e.g. through an executive summary of the results).

Recommendations from the findings:

In light of the above, a number of recommendations are made based on this work. These are outlined below[6].

Implications for Parental Health and Well-Being in ADHD

Parental health and well-being, particularly maternal health, was highlighted in previous literature to be vulnerable for parents of children diagnosed with ADHD. Such vulnerabilities were highlighted in chapter 2 and 3 and included: maternal stress and depression, low satisfaction with parenting and quality of life, physical health problems etc. Considering the vulnerability of this population in the literature, it is useful to speculate on the value that such a diagnosis may have for parents and on how parental empowerment may occur in relation to ADHD and treatment choices. This is expanded below.

The Limitations of a Diagnosis

In the qualitative literature on ADHD, there was dispute over the benefits of an ADHD diagnosis for parents. While some contributors argued that ADHD provided an exonerating concept for parental blame and responsibility, others maintained that the complexities of the situation. Singh (2004) and Bull et al (2006) maintained that

[6] These recommendations will form the basis of an executive summary of the research to be disseminated to the NHS Local Health Council and Quality Improvement Scotland, the local education council and holistic charity.

ultimately a diagnosis was limited for parents and for management of the condition. Clearly there were other benefits for parents in having a diagnosis of ADHD such as having a name for the difficulties, as well as practical implications such as receiving resources such as Disability Living Allowance (in the UK) or extra school support for example. However, ultimately the diagnosis was limited in terms of management as well as responsibility.

The present study from a critical discursive psychological approach highlighted that talk about ADHD was temporal and negotiated in research interviews. It highlighted that such talk was oriented to parental accountability and moral adequacy as parents. Such talk was tied to competing ideologies within child developmental theories and current biopsychosocial models for ADHD which implicated such parental accountability. In essence then, this work maintains the limits of an ADHD diagnosis in keeping with previous authors such as Singh (2004) and Bull et al (2006). It is argued that the focus on parental responsibility in such talk, further works to obscure broader aspects in contemporary culture which are not given sufficient scope. The limits of a diagnosis were clearly highlighted through the complex discursive work that parents were engaged in, in order to achieve the 'good parent' identity. For example: through making available talk about other 'non-ADHD' children and talk orienting to the good character and adequacy of the parenting. Thus the recommendation is that medical professionals recognise the limitations of a diagnosis for parents; that it is not an exonerating concept but that parental responsibility is a pervasive feature of contemporary culture. Clinicians such as Timimi (2005) have argued for a collaborative, systemic approach with families, which doesn't depend on diagnosis. Finally, this work does not dispute that there may be other practical benefits associated with a diagnosis of ADHD for parents, such as Disability Living Allowance, however from a critical perspective it maintains that a diagnosis is ultimately limited.

Parental empowerment through specialist ADHD knowledge

Active parental political efforts at knowledge dissemination and lobby may be used as a means of providing parents with an active, engaged and empowered role. In the UK these efforts can be seen as lay appropriations in order to achieve greater medicalisation of children's difficulties as ADHD. These efforts paralleled Rafalovich's (2004) finding that parents armed themselves with information and

knowledge about ADHD. However, the political connotations of such efforts should be recognised. In the analysis parental talk used the 'out there' device and analogy with cancer as a means of holding on to such divergent constructions for ADHD with schools and families. What was significant was that parental talk used such ADHD expertise in order to undermine alternative constructions of the child's difficulties which implicated their own parenting. While such efforts may be understandable, it is maintained that these efforts will achieve greater effectiveness with the increases in diagnoses. Further, this has implications for health professionals and educators who may be increasingly confronted with such 'lay experts' on ADHD and so provides understanding of how such knowledge claims may be used by parents.

Treatment choices

In parental talk about medication, two ways of talking about the medication were highlighted. Both of these constructions are in divergence with health policy guidelines for ADHD which emphasise the 'package' approach. In talk about medication as having no other options, parental talk achieved an essentially passive and disempowered position in relation to choices about treatment. In these accounts, parents oriented to dire external situations in which there was no other option available and a subject position of a reluctant user of such medication for their child. It is argued that such a position is in contrast to guidelines which emphasise the medication as part of a package. Further, that medical professionals should encourage parental engagement with and active choice about such options.

In the second positioning, parents oriented to their efforts as one of 'resistance' in relation to refusing medication as a treatment for their child's difficulties. 'Resistance' to medication in ADHD has not previously been given much scope in ADHD research. In such positioning, parental talk oriented to inner, personal qualities such as strength and willpower, or intelligence and resourcefulness in order to actively pursue alternative options and refuse medication. Clearly the recommendation here is for medical professionals to have greater awareness of empowerment aspects and difficulties in refusing such treatments, as well as respecting parental choice with regards to treatment medication. With the recent findings by the MTA study (e.g. Jensen et al, 2007) released which highlighted the limits of medication in the long-term, it is clear that such medications should not be regarded as the 'gold standard' or monopoly on

treatment. Such professionals should recognise the appeal of such alternative and complementary approaches for parents. Ultimately, in keeping with other critics, it is argued that parents be offered an 'informed choice' regarding medication and that this occur in collaborative efforts.

Implications for Teachers, Educational Policy and ADHD

Analysis of teacher talk about children's difficulties highlighted how teachers succeeded in constituting alternative accounts for the child's difficulties in relation to ADHD diagnoses. Teachers oriented to experiential knowledge in this regard. These discursive constructions were shown to be linked to educational guidelines produced about ADHD in relation to *Pseudo* ADHD. In effect, the very notion of Pseudo ADHD, it is argued, provides a means of constituting children's difficulties in such terms as opposed to ADHD explanations (which exist in these narratives only as an abstract entity).

Efforts at Teacher Education in ADHD

It is argued that efforts at knowledge dissemination about ADHD to schools and teachers may be limited in the face of robust explanations. ADHD has been likened to diabetes by proponents such as Russell Barkley due to the complexities involved in managing the condition and because most of the care remains with the patient rather than the professional. In complex diseases such as diabetes, however, it is recognised that compliance or adherence efforts to treatment protocols do not purely depend on education and knowledge (e.g. Glasgow and Anderson, 1999). Instead, complex collaborative efforts have been regarded as more effective. Thus, like diabetes management, educational efforts that depend on the education of 'ignorant' teachers about ADHD, without utilising teachers' alternative constructions for ADHD and parenting may appear ineffectual. It may be more pragmatic to engage such alternative constructions in order to encourage debate about this topic for management. In addition, it is necessary to consider wider educational institutional policies, theories and guidelines (e.g. Cooper and O' Regan, 2001) and their role in maintaining these alternative constructions (i.e. as external stressors centred on 'poor' parenting). The present study highlighted that in many ways 'insufficient' knowledge about ADHD was an inadequate explanation for teachers'

competing versions about children's difficult behaviour. Indeed, teachers did proclaim a lack of knowledge on the topic (i.e. through associations of 'I don't know' with the ADHD repertoire). However, there was also a range of talk which demonstrated elaborate talk about the current limits in the research to do with the ADHD construct and medications effects. It was argued in this study that broader aspects of teacher empowerment and control were clearly significant in relation to how teachers were undermined by such medical accounts of children's difficulties. Clearly there is a need to address the marginalisation of educators from such increasing medicalisation efforts. It was further noteworthy that such alternative constructions to ADHD by teachers appeared as a sensitive topic to articulate in research interviews and further that as ADHD diagnoses increase so too will such explanations be more difficult to achieve.

The value of Teacher accounts

Clearly teachers had very different constructions about children's difficulties to those of the parents. They were much less likely to hold a medical perspective for such difficulties. Much has been made of the differences of views between parents and teachers (i.e. parental 'battles' with school staff over the differences in the UK) or over teachers and clinicians (i.e. in North America). However, there may be benefits and value in having alternative explanations for children's difficulties. Different constructions may have value for the field of ADHD. Watling (2004), for example, has argued that teachers – along with health professionals – may have an important role in the exclusion of pupils with special educational needs (i.e. which frequently involves pupils diagnosed with ADHD). He argued that by disrupting each other's practice, such professionals can ensure that they do not reify the status quo by such collaboration and contribute to practices which ultimately increase exclusions. Thus it is argued likewise, that there may be benefits to harnessing teachers' constructions in the UK, as collaborating professionals.

Implications for Parent and Teacher Communication about ADHD

Ultimately recommendations based on this work for parent and teacher communication are limited because this work did not focus on such interactional encounters. Nevertheless, the findings based on such in-depth exploration of

parental and teacher talk from research interviews does have implications for this area. Clearly the area of parent and teacher communication is an important one, particularly when difficulties are exhibited in the classroom. This work calls for communicative efforts which transcend the individual responsibility (and blaming) for child health which characterise contemporary cultural assumptions. Instead broader social, cultural and structural influences which function to ensure that the child's difficulties appear as problematic should receive greater attention. In terms of communication between parents and teachers about ADHD, it is argued that it is necessary that greater efforts be expended on such structural and economic barriers and wider contextual issues around difficult behaviour. The propensity to blame parents – and teachers through ignorance and bias – should be discouraged and acknowledged as a central feature underlying common cultural assumptions. For example, during school review meetings with parents, educators and professionals, counter-explanations to ADHD should be actively explored and the limits of a diagnosis recognised. In addition, wider cultural and educational discourses could be explored for their potential to move beyond individual propensities for blame and which challenge such medical constructs.

Implications for Child Well-Being and ADHD

Child well-being was unexpectedly lowly ranked in the UK and the USA according to the recent UNICEF (2007) report. In these cultural contexts, the medicalisation of children's difficulties as ADHD occurs readily and with increasing frequency in the UK. It may be argued that such processes of medicalisation may actually work to obscure the meanings of such behaviour within the context of which it occurs for the children themselves. The effect of such medicalisation practices for children's behaviour ensure that the adult 'gaze' is directed at symptoms of disruption, over-activity and behaviour as potential instances of 'disorder'. Such medicalisation process ensures that lay parents and teachers are interpellated, in Althusser's (1971) terms, into such medical processes as opposed to directing attention to wider 'pathological' aspects of the social, cultural and economic systems which underlie and undermine child well-being in these contexts. Such practices are a feature of Western individualistic assumptions which hold individuals accountable for problems/deviations from the norm and which decontextualise such individual

pathologies from wider social milieu. Clearly the recommendation is that the area of child well-being be given greater scope and attention.

Implications for Child Development Theories and ADHD

In chapter 4, Burman's (1994) critique of the underlying assumptions underpinning developmental psychology was highlighted. Such assumptions were in relation to a consideration of the predominantly North American context in which such theories originated, the individualistic focus on the child at the expense of the child within the broader social context (i.e. society and culture), an emphasis on the mother-child dyad at the expense of other significant adults and the emphasis on a normative basis for the successful accomplishment of developmental milestones. With the emphasis in such developmental theories on the significance of the maternal, Burman (1994) argued that the implication was that a child that was developmentally delayed or different invoked a 'failure' on the part of the mother. While Burman's (1994) critique may be considered sweeping for capturing the diversity of contemporary child development theories; for example: ranging from social learning theory to Bronfenbrenner's (e.g. 1979) ecological theories which, to varying degrees, recognise environmental influences on development. However, it may be argued that contemporary child development theories largely reflect cultural assumptions inherent in Western, industrialised cultures. Thus, while there may be greater consideration of such environmental influences, it is argued that contemporary theories are still oriented towards individuo-centred dualisms. Such dualism implies the separation of the individual from the social and that individual behaviours can be measured and quantified; which tends to parallel mainstream psychology more generally. Within this paradigm, the influence of the environment is reduced to quantifiable 'variables' and it is argued that a form of reductionism occurs.

Thus, the implications of the present findings for child development theories are to highlight how lay people draw on such theories in their own idiosyncratic and hybrid ways in everyday language. From a discourse analytic perspective, such variability in accounts is not surprising. From parental narratives, although a wide array of environmental influences were specified in relation to the environmental repertoire, it was significant that these always implicated notions of parental accountability and blame (i.e. parental divorce; separation anxiety; stress during

pregnancy) as opposed to other influences. In the teacher analysis, moreover, teacher's talk drew from current developmental theories (i.e. attachment theory and social learning theory). It was noteworthy that from these wider developmental and educational discourses that teachers rendered parents as central in the development of difficulties from talk about educational practice; this also tended to obscure wider environmental influences such as schooling and teacher's actions. Thus such talk highlights the reductionistic tendencies inherent in such theories when they are taken up in lay talk. The underlying tendency and availability for talk by *both* parents and teachers to orient towards parental accountability as a defining feature of the child's difficulties is significant and indicates the pervasiveness of parental blame in current contemporary culture. The relevance, therefore, of the findings are to highlight this individuo-centred parental blame as a persistent feature in lay everyday talk about children with difficulties such as ADHD. Thus Burman's (1994) original contention that mothers of children with difficulties were particularly implicated as 'failures' is endorsed and extended to parents of children with an ADHD diagnosis as discussed here. From the analysis, it is therefore argued that it was very difficult for parents to extricate themselves from notions of causality in ADHD and from a variety of theories within child development which implicated the central role of their parenting as key within their child's development of difficulties. Hence it may be argued that contemporary child developmental theories as well as current educational discourses require greater consideration of this pervasive and inevitable cultural feature in which environmental aspects of child development appear reduced to the parents or mother. Such theories require greater consideration of how lay narratives take up such theorising which is an important application. Such individuo-centred cultural assumptions remain rooted within contemporary culture.

Implications for Critical approaches to ADHD

While the process of the medicalisation of children's difficulties in the UK is a relatively recent phenomenon (through the greater adoption of the DSM classification), it has achieved greater acceptance in the biomedical community. However, it has met with reluctance and ambivalence elsewhere. This will be considered further.

Critical approaches to health and illness have themselves been the subject of critique. For example, a recent debate in *The Psychologist* as initiated by Boyle (2007) argued over the merits and limits over DSM-IV criteria for psychologists. For ADHD particularly this was a controversial topic. Singh (2002) too, espoused the limits of critical approaches to ADHD. Wider debate in the area of critical health psychology, for example, over the contribution which such critical approaches may make to public health is also relevant (e.g. Prilleltensky and Prilleltensky, 2003; Hepworth, 2006; McVittie, 2006). One area in such debate has been over whether critical approaches in health psychology can contribute to alternative conceptions and action. Others have maintained the plurality of the field of critical health psychology and suggested that critique may be levelled at both micro aspects as well as more macro aspects.

In light of the above, the present critical focus on 'micro' aspects of talk about ADHD is a valuable area for critical health psychology. For example, the limitations of the biopsychosocial model of ADHD in parental talk in relation to biological reductionism were highlighted in relation to empirical data and which paralleled such broader health policy documents (i.e. with the emphasis on medication as treatment). It is recognised here that critical approaches to ADHD are insufficient merely for being critical. The benefit of a critical approach to ADHD, as maintained throughout, is that it allows critical debate on a controversial topic. This is particularly apt in an area such as ADHD where there is increasing use of broader definitions of the classification, despite so called evidence base for organic pathology which would substantiate these increases. The continued rise and use of this classification in a UK context means that such critique appears forestalled (at least in the medical community; or in marginal contributions such as sociology). The challenge remains for such critical approaches to filter and impact in such medical domains, so that critical debate is encouraged rather than subdued. The contribution of this critical work is to offer an empirical analysis of parental and teacher talk in an effort to consider the limits of such conceptualisations for agency. This approach has explored positioning for parents and teachers in talk about ADHD and contributes to critical debate on this topic. In the wider and growing acceptance of ADHD diagnoses in the medical community, such debate is relevant and topical.

Conclusion

This work has highlighted how parent and teacher talk takes up children's difficulties as ADHD. It has been argued that the greater medicalisation of children's difficulties as ADHD needs revisiting in a UK context. Parents and teachers were shown to be ultimately disempowered in terms of the subject positions available in talk about this topic. This is significant particularly when considering how parental well-being is important in the care and management of difficult behaviour and which has shown to be particularly vulnerable for this population. Thus, it has been argued that such increasing medicalisation has particular social and psychological consequences for parents and teachers which warrant consideration in current conceptualisations of children's difficulties. Previous approaches to ADHD have tended to focus on genetic explanations or parenting influences without regard to broader influences of the social milieu in which such behaviour takes place. This thesis has been an attempt to address these issues by focusing on everyday social processes of ADHD by lay people. The work highlights how current approaches as ADHD are limited in terms of the biomedical and biopsychosocial to the realm of children's behaviour. This does not mean that we see a return to the issue of parental blame for the child's behaviour (i.e. in such labelling as 'naughty' or 'bad children'). Instead, the very individualist assumptions underlying contemporary practices should be challenged because they mean that the broader social milieu escapes scrutiny. Indeed, while the benefits of medicalisation itself have been previously shown for parents through having a name for the difficulties or by gaining access to resources such as disability living allowance or extra school support etc. However, ultimately it is argued that such efforts are limited in the medical colonisation of this realm both for what can be done and for who is to blame. Parents and teachers play a central role in this area and were shown to be disempowered in their talk about this topic. This work implicates the intersection of contemporary socio-cultural and historical practices towards children's difficulties as contingently formed and as socially practised in unique and novel ways by parents and teachers in an area of Scotland. It is argued that ultimately, the efforts aimed at challenging contemporary constructions of ADHD should be aimed at both the individual speaker and the wider cultural context.

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Appendices

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Appendix 1: Information sheet for parent participants

Queen Margaret University College
EDINBURGH

PARENT INFORMATION SHEET
Talking about Childhood Attention Deficit Hyperactivity Disorder (ADHD): A Study Amongst Children, Parents, Teachers and Health Professionals.

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

My name is Carol Gray. I'm doing my PhD at the Department of Psychology, Queen Margaret University College, Edinburgh. My research investigates how different groups of people talk about and experience Childhood Attention Deficit Hyperactivity Disorder (ADHD).

ADHD is one the most widely researched and yet poorly understood childhood conditions. It's also one of the most common childhood conditions. I'm interested in what this condition means to you and your family. Your experiences as a Parent are valuable.

Why have I been chosen?
I am looking for volunteers to take part in this study and would like to talk to you because you are a Parent of a child diagnosed with ADHD. I will be talking to 15-20 families.

What does the research involve?
If you decide to take part in the study, you will be asked to take part in an interview with me, lasting between 1-2 hours. You will be asked some questions about your experiences of having a child with ADHD. There are no right or wrong answers, your experiences are valuable and important.

If possible and with your permission, I would like to speak to your child about his or her views.

After speaking to you and your child, I would like to speak to your child's teacher and a health professional involved with your child's care for ADHD (for example doctor, psychiatrist, psychologist, nutritionist). I would need to contact them and invite them to take part in the study. If you'd prefer me not to contact your child's teacher and/or health professional then that would be fine too.

Is the research confidential?
Yes. The research is completely anonymous and confidential. Interviews are recorded for research purposes but only the researcher and the university

supervisors will have access to the recordings and interview transcripts. Your name will be replaced with a pseudonym, which is a false name, and it will not be possible for you to be identified in any reporting of the data gathered. The results are examined cumulatively, this means that your personal views are not shared with others (for example your child's teacher or health professional).

What will happen to the results of the research?
The findings of this research will contribute to greater understanding of what it's like to be a parent with a child diagnosed with ADHD in Scotland. The results may be published in a journal and/or presented at a conference. You will not be able to be identified in any report/publication.

What happens next?
It is up to you to decide whether or not to take part in the study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You'll be given a copy of the consent form to keep. If you do decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care that you or your child may be receiving.

Where would the interviews take place?
The interviews will take place at a time and a place that is convenient for you and your family. They could be at your home or they could be at Queen Margaret University College. Should your participation involve travel to QMUC, you will be reimbursed for out-of-pocket expenses.

Where can I get more information?
You can contact me for more information: **Carol Gray**
PhD Student, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS
Tel: 0131-317 3619/ 07810332801
Email: cgray@qmuc.ac.uk

If you would like to talk to an independent person who knows about this study but is not involved in it, you could contact: **Michele Hipwell,**
Lecturer, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS
Tel: 0131-317 3611
Email: mhipwell@qmuc.ac.uk

Thank you very much for reading this information sheet!

PIS 2 July 2005

Appendix 2: Information sheet for teacher participants

Queen Margaret University College

EDINBURGH

TEACHER INFORMATION SHEET

Talking about Childhood Attention Deficit Hyperactivity Disorder (ADHD): A Study Amongst Children, Parents, Teachers and Health Professionals.

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

My name is Carol Gray. I'm doing my PhD at the Department of Psychology, Queen Margaret University College, Edinburgh. My research investigates how different groups of people talk about and experience Childhood Attention Deficit Hyperactivity Disorder (ADHD).

ADHD is one the most widely researched and yet poorly understood childhood conditions. It's also one of the most common child conditions. I'm interested in what this condition means to you based on your experiences. Your experiences as a Teacher working with children with ADHD are valuable.

Why have I been chosen?

You have been chosen because you a teacher of a child with ADHD, whose family is currently taking part in this research. The family have agreed that I contact you. You are invited to be part of this research to share your experiences. I'll be speaking with 15-20 families.

What does the research involve?

If you decide to take part in the study, you will be asked to take part in an interview with me, lasting approximately 30 - 45 minutes. You will be asked some questions about your experiences of working with a child/children with ADHD. There are no right or wrong answers, your experiences are valuable and important.

I will also be speaking to the health professional involved with the family's care for ADHD.

Is the research confidential?

Yes. The research is completely anonymous and confidential. Interviews are recorded for research purposes but only the researcher and the university supervisors will have access to the recordings and interview transcripts. Your name will be replaced with a pseudonym (a false name) and it will not be possible for you to be identified in any reporting of the data gathered. The results are examined cumulatively, this means that your personal views are not shared with others (for example the parents or health professionals).

What will happen to the results of the research?

The findings of this research will contribute to greater understanding of what it's like to be a teacher working with a child diagnosed with ADHD in Scotland. The results may be published in a journal and/or presented at a conference. You will not be able to be identified in any report/publication.

What happens next?
It is up to you to decide whether or not to take part in the study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You'll be given a copy of the consent form to keep. If you do decide to take part you are still free to withdraw at any time and without giving a reason. If you decide to take part in the study, please indicate this on the reply slip and return it with the consent form, in the enclosed envelope. Should you decide not take part, please indicate this on the reply slip and return it in the enclosed envelope.

Where would the interviews take place?
The interviews will take place at a time and a place that is convenient for you and your schedule. They could be at your school or they could be at Queen Margaret University College. Should your participation involve travel to QMUC, you will be reimbursed for out-of-pocket expenses. Alternatively, interviews could take place over the telephone, if this is more convenient.

Where can I get more information?
You can contact me for more information: **Carol Gray**
PhD Student, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS
Tel: 0131-317 3619/ 07810332801
Email: cgray@qmuc.ac.uk

If you would like to talk to an independent person who knows about this study but is not involved in it, you could contact: **Michele Hipwell**
Lecturer, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS
Tel: 0131-317 3611
Email: mhipwell@qmuc.ac.uk

Thank you very much for reading this information sheet!

TIS2 July 2005

Appendix 3: Consent form for parent participants

Queen Margaret University College
EDINBURGH

CONSENT FORM FOR PARENTS

Title of Project: Talking About Childhood Attention Deficit Hyperactivity Disorder (ADHD): A Study Amongst Families, Teachers and Health Professionals.

Name of Researcher: Carol Gray, PhD Student, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS

Please initial box as appropriate

1. I confirm that I have read and understand the information sheet dated July 2005 (version 2) for the above study have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I consent for the interview to be recorded for research purposes ☐

4. I consent for my child to take part in a research interview ☐

5. I consent for the researcher to contact my child's teacher to take part in a research interview ☐

6. I consent for the researcher to contact my child's health professional to take part in a research interview ☐

7. I agree to participate in this study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

PC1 July 2005

Appendix 4: Consent form for teacher participants

Queen Margaret University College

EDINBURGH

CONSENT FORM FOR TEACHERS

Title of Project: Talking About Childhood Attention Deficit Hyperactivity Disorder (ADHD): A Study Amongst Families, Teachers and Health Professionals.

Name of Researcher: Carol Gray, PhD Student, Department of Psychology, Queen Margaret University College, Clerwood Terrace, Edinburgh EH12 8TS

Please initial box as appropriate

1. I confirm that I have read and understand the information sheet dated July 2005 (version 2) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

3. I consent for the interview to be recorded for research purposes ☐

4. I agree to participate in this study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

TC1 July 2005

Appendix 5: Poster advertising for participants at holistic charity

Queen Margaret University College
EDINBURGH

VOLUNTEERS NEEDED:
PARENTS OF CHILDREN WITH ADHD

Are you a parent with a child diagnosed with ADHD?

Would you be willing to talk to me about your experiences?

ADHD is one of the most widely researched but poorly understood child conditions. It's often in the media. But what does it mean to YOU and YOUR family?

I'm a PhD student researching the meaning of ADHD for families and children, as well as professionals.

All interviews are confidential and anonymous and you are free to withdraw anytime.

Contact CAROL GRAY for more information:
07810332801 or 0131-317 3619
CGray@qmuc.ac.uk

Thank you! Pos 1 June 2005

Appendix 6: Topic guide for participants

1. Parent Topic Guide

Your Child
ADHD
The Story of Diagnosis
Causes of ADHD
Treatment and Help
Dealing with Doctors/Medical staff
Dealing with Teachers/School
Coping
Future

2. Teacher Topic Guide

Pupil with ADHD/others with ADHD
ADHD
Diagnosis
Causes
Treatments/Help
Dealing with Parents
Dealing with Doctors/Medical staff
Dealing with other teachers/education psychologists/etc
Coping

TG1 April 2005

Appendix 7: Interview schedule for parent participants

Parent Interview Schedule

- Tell me about your child
- Who first noticed the difficulties
- What is ADHD/What does ADHD mean to you
- Information & knowledge about ADHD
- How did your child come to be seen as having ADHD/who diagnosed/how did they diagnosis/time taken
- How did you feel when you first received this diagnosis/now
- Has it been helpful having a diagnosis
- How do you think your child came to have ADHD/origins of the child's difficulties
- What/ Is there anything that tends to help
- What kinds of help or treatment where you offered
- How did you decide on what to do
- Medical help/other support/alternative support
- How do you feel about the help or treatments you received/medication
- How does your child feel about this
- Tell me about your relationship with doctors/health professionals
- Is/what has been helpful
- Tell me about your relationship with teachers/school
- Is/what has been helpful
- How have other people reacted
- ADHD and the media
- How do you feel about the controversial nature of ADHD
- Please tell me about your own health
- How have you coped as a family/support
- What do you think the future means

Debriefing

- Is there anything you'd like to add or comment on about what we've discussed so far
- Please tell me what it's been like talking about your experiences today

Appendix 8: Interview schedule for teacher participants

Teacher Interview Schedule

- Please tell me what ADHD is/ means from your perspective
- What is ADHD from your understanding
- What are your views on ADHD
- Tell me about your experiences with pupils with ADHD
- Tell me about how significant ADHD is in your school/class
- Can you describe how a child with ADHD might behave
- How do you think a pupil comes to have ADHD
- Tell me about what you see as the role of the parent in causing ADHD/managing ADHD
- Tell me about what you see as the role of the school/teacher in managing ADHD
- Do you think it's useful to have an ADHD diagnosis from your perspective
- Tell me about any knowledge or training you've received for ADHD
- Are you satisfied with the training/sufficient
- Was this training something provided to you or did you actively seek it out
- Have you ever been involved in a diagnostic process for ADHD (either being consulted over a pupil or referring a pupil for assessment)
- Do you think schools should be involved in the diagnostic process/ why
- Please tell me what the main issues are for a teacher with a pupil with ADHD
- (Please tell me what the main issues are for a pupil with ADHD at school)
- Have you ever been involved in supporting a pupil with ADHD or as part of the treatment for ADHD – If yes tell me about that – Have you ever been involved in any medical management for ADHD
- Do you think schools should be involved in supporting pupils with ADHD
- Please tell me how you tend to manage in the classroom for ADHD type behaviour
- What do you think tends to help for ADHD or ADHD type behaviour
- Tell me about the kinds of support that is available for you / teachers with pupils with ADHD/enough
- Have you ever interacted with parents about their child's ADHD – If yes, tell me about that
- Have you ever interacted with medical staff over ADHD – If yes tell me about that
- Have you ever discussed ADHD with other education staff – If yes tell me about that
- Have you ever experienced any problems in communication about ADHD – if yes tell me about that
- Tell me what the important issues are about ADHD for you
- Is there anything you would like to discuss that we haven't covered so far

Appendix 9: Transcription conventions used

Simplified transcription notation

(Based on Gail Jefferson, Atkinson & Heritage, 1984)

I: interviewer

P: Parent participant

M: In a joint interview, refers to the mother as speaker

F: In a joint interview refers to the father as speaker

T: Teacher participant

(.): untimed pause

=: indicates overlapping talk

Italics*:* indicates talk that is emphasised

underlined: indicates talk that is much louder than surrounding talk

(text): unsure of accuracy of text or missing text

[text]: information added by interviewer